Supreme Court, U.S.
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88-957
Case No.

IN THE UNITED STATES SUPREME COURT
TERM: OCTOBER 1988

Vincent S. Toussaint, M. D.,
Petitioner

v

Laurens County Health Care System, Russell Emersom, Edward M. Corley, Walter A. Sigman, W. Paul Culbertson, L. W. McClain, Michael R. Meeks, James L. Waler, Reese Young, James G. Ferguson, W. M. Wiley, individually and in their official capacity as members of the Board of Directors of Bailey Memorial Hospital, and Clem P. Ham, individually and in his official capacity as Administrator of Bailey Memorial Hospital, Akhtar Hussain, M.D., individually and in his official capacity as Chief of the Medical Staff at Bailey Memorial Hospital and as a member of the Executive Committee of Bailey Memorial Hospital, Bruce Marshall, M.D., individually and in his official capacity as a member of the Executive Committee of Bailey Memorial Hospital, Stephen Ramsay, M.D., individually and in his official capacity as a member of the Executive Committee of Bailey Memorial Hospital and as Chief of Service for Pediatrics,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the trial court erred in that the findings of fact are clearly erroneous?
2. Whether the trial court erred in concluding that petitioner failed to sustain his causes of action for violations of 42 U.S.C. 1983?

PARTIES

The caption contains the names of all parties.

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APPENDIX

Reference to Opinion and Orders in Lower Courts

A. United States Court of Appeals for the Fourth Circuit

1. Opinion of Court of Appeals dated September 7, 1988, affirming the judgment of the United States District Court. A-2
2. Judgment of the Court of Appeals dated September 7, 1988, affirming the judgment of the United States District Court. A-17-2

B. United States District Court for the District of South Carolina

1. Order of the United States District Court dated November 24, 1987. . . . . A-18
2. Judgment of the United States District Court dated November 27, 1987. . . . A-103

JURISDICTION

1. The judgment of the United States Court of Appeals for the Fourth Circuit sought to be reviewed in this matter was rendered on September 7, 1988, and entered on September 7, 1988.
2. Section 28 United States Code 1254(1) confers jurisdiction on this Court to review a judgment of a United States Court of Appeals in a civil case by writ of certiorari.

CONSTITUTIONAL PROVISION INVOLVED

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws. Section One of the Fourteenth Amendment to the Constitution of the United States of America.

STATUTORY PROVISION INVOLVED

Every person who under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of

the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. For the purpose of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia. 42 United States Code 1983.

RULE OF CIVIL PROCEDURE INVOLVED

Effect. In all actions tried upon the facts without a jury or with an advisory jury, the court shall find the facts specially and state separately its conclusions of law thereon, and judgment shall be entered pursuant to Rule 58; and in granting or refusing interlocutory

injunctions the court shall similarly set forth the findings of fact and conclusions of law which constitute the grounds of its action. Requests for findings are not necessary for purposes of review. Findings of fact shall not be set aside unless clearly erroneous, and due regard shall be given to the opportunity of the trial judge to judge of the credibility of the witnesses. The findings of a master, to the extent that the court adopts them, shall be considered as the findings of the court. If an opinion or memorandum of decision is filed, it will be sufficient if the findings of fact and conclusions of law appear therein. Findings of fact and conclusions of law are unnecessary on decisions of motions under Rule 12 or 56 or any other motion except as provided in Rule 41(b). Rule 52(a) of the Federal Rules of Civil Procedure.

STATEMENT OF THE CASE

Petitioner initiated this action in the District Court based on the existence of a federal question arising under rights guaranteed pursuant to the Fifth and Fourteenth Amendments to the Constitution of the United States and provisions of 42 United States Code 1983. Jurisdiction was also established pursuant to 28 United States Code 1343. The amount in controversy exceeds $10,000.00 but was not necessary to establish jurisdiction.

Petitioner is a board certified general surgeon. Respondents are: the Laurens County Health Care System, a political subdivision of the State of South Carolina; its board of directors, individually and in their official capacities; the executive committee of Bailey Memorial Hospital, individually

and in their official capacities; and the administrator of Bailey Memorial Hospital individually and in his official capacity. The complaint alleged in separate causes of action: (1) that Respondents and others, both known and unknown, had conspired to and had deprived Petitioner of his liberty and property without due process and (2) had deprived him of his liberty and property without due process. The case was tried nonjury, and the Court granted judgment for Respondents. The Court of Appeals affirmed finding that the standards by which Petitioner was evaluated met the requirements of substantive due process in the context of staff privileges because the law does not require the hospital to prescribe exact rules and that Petitioner was afforded procedural due process.

Petitioner lives in Clinton, South

Carolina, was educated in Paris, France; England; the Netherlands; Canada; and Greenville, South Carolina; graduated from medical school at Leiden University in the Netherlands; there completed an internship in general practice and completed another year of internship in general practice at Queen Elizabeth Hospital in Montreal, Canada, teaching hospital for Magill University. He completed his military requirements, worked in Africa as a church doctor, worked as a general practitioner and then enrolled in a four and half years surgical residency program at the Greenville Hospital System which ten physicians started and five finished. During his residency a professor from Richmond, Virginia, introduced the residents to a "brand new surgical procedure", the selective vagotomy.

Petitioner was chief resident, was later board certified by the American Board of Surgery and passed his recertification exam in 1986. (A. 446-448).

During his residency he moonlighted in the emergency rooms of Bailey Memorial Hospital in Clinton. In his last residency year, Fred Crawford, the then administrator, asked Petitioner to join the staff at that hospital. Crawford told Petitioner that there was not a surgeon in Clinton, but Petitioner later found general practitioners performing surgery and inferred that Crawford wanted to expand available surgical procedures. Crawford met Petitioner at the airport in Clinton, showed Petitioner a house, said a loan had been already arranged, took Petitioner to the hospital and showed him a new office complex attached to the hospital. Petitioner agreed to stay, went to the bank, got the

loan on the house that day and started his practice the same day he completed his residency. (A. 448-451).

He went to the other doctors' offices to make his acquaintances. The first doctor visited was Respondent Walker. Petitioner told Walker that he was starting a surgical practice. Walker said the medical staff didn't know Petitioner had decided to move to Clinton, that the hospital was not suited for major surgical procedures, that the staff had not anticipated a surgeon moving there, that the hospital was "more like a Red Cross center" and that Walker "didn't feel that a general surgeon would be of any great necessity at that time." (A. 451-452).

During his first year in Clinton, he did a peripheral vascular procedure. There was plenty of blood in the blood

bank. He arranged for a general surgeon to come to assist and arranged for the anesthesia. An intensive care unit was readied by training the nurses to raise the level of care to an acceptable level. Out-patient arteriograms were done and arteriograms could be done during the operation. Standard procedure for such patients in Clinton had been amputation of the limb, but this patient's limb was revascularized. The patient did well. During the procedure Walker's partner came into the operating room and objected. Walker represented a faction of the medical staff that later objected to performance of the procedure in Clinton. Petitioner was prohibited from doing the procedure despite an objection to the prohibition by the then board of directors and now refers patients in need of the procedure to Self Memorial Hospital in Greenwood. (A. 453-457; see

also 224-236; 953).

About the same time an audit of splenectomies was performed. Petitioner was unaware of the audit or the criteria used but was informed of the result and understood that a member of the medical staff had requested the audit. (A. 457). The audit was conducted by a regional audit committee for seven small towns. Audit topics could be requested by anyone. Hospitals did not have to accept the proposed audit results. Dr. Stanley Baker, a board certified surgeon practicing in Greenwood, served on the audit committee which concluded that two of three splenectomies were not justified. Petitioner was the only physician who had done splenectomies in Clinton. (A. 397-402; 1402-1405). In July of 1977 the proposed audit was rejected by the medical staff which

concluded that all of the splenectomies were justified. (A. 178; 954-955). Baker was also a member of the board of the South Carolina Medical Care Foundation which functioned as the federal Physicians Standards Review Organization (PSRO). (A. 400). In January of 1977 Baker submitted the proposed audit to Dr. William Cantey, medical director of the PSRO. (A. 1406). On June 1, 1977, the PSRO returned the splenectomy audit to Baker because of "inconsistencies as to whether or not the study (had) actually been completed and whether proper procedures were carried out prior to forwarding this matter to us." The correspondence was copied to Walker, as chief of staff. (A. 956). On June 10, 1977, Dr. Baker wrote to Crawford and told Crawford that the proposed audit on splenectomies identified a deficiency, that the

regional audit committee had no disciplinary authority and that it was the responsibility of the hospital's governing body to take action. The letter was copied to Walker, as chief of staff, and to W. C. Neely, as chairman of the board. (A. 1409). When asked if he had joined with any other parties in actions to try to get rid of the plaintiff Neely responded that he could not recall. (A. 244). In July of 1977 Petitioner was either denied privileges at Laurens District Hospital or withdrew his application based on the advice of his attorney, Mr. McAlister. (A. 701-703; 929-936).

In 1978 the regional audit committee did an audit on vagotomies. The audit did not differentiate between the kinds of vagotomies. The parietal cell, selective vagotomy was very modern and

was done by very few surgeons. The advantage of the procedure is that the stomach does not have to be opened, there is no recorded mortality, patients leave the hospital quickly and have little blood loss, but because the procedure was so new it was controversial. The trunkal vagotomy with pyloreal plasty and trunk vagotomy with hemogastrectomy were the standard procedures. The different procedures were "piled together in the same audit." (A. 458-459). Baker testified that the state PSRO selected the topic for audit committees statewide and developed the vagotomy criteria which was used by the regional committee. The proposed audit included procedures performed in Clinton only by Petitioner, audited 25 vagotomies performed by Petitioner and concluded that 18 were not justified. (A. 405-408; 1098-1107). The surgical committee at Bailey Hospital

reviewed and rejected the proposed audit concluding that all the vagotomies were justified, criticized the examiners for basing their conclusions on inadequate records, disagreed with the observation that selective vagotomy was outside the realm of a small community hospital and while recognizing that the procedure was controversial noted that there had been "proven successes with upper G.I. disease in numbers of these patients." (A. 1108-1109) Baker submitted the committee's vagotomy audit to the PSRO in March of 1978. (A. 407-408; 1407) Pursuant to Section 1160 of the Social Security act (42 U.S.C. 1320, et sequiter), the PSRO evaluates physicians' services to medicare and medicaid patients pursuant to norms which are used as criteria. 42 U.S.C. 1320c-4; 42 U.S.C. 1320c-5(a)(b)(c). One vagotomy

was a medicaid case while 20 were paid by commercial insurance, 2 by private insurance and 2 by Blue Cross-Blue Shield. (A. 1111). On April 14, 1977, Baker wrote to the PSRO chairman and reported a "plan of action" which was: the audit committee obtaining all of Petitioner's surgical charts from March 1977 to September 1977; doing a total chart review every two months; submitting reports to the PSRO and forwarding unjustified cases for PSRO evaluation. Baker copied the letter to Walker, as chief of staff, and Cantey of the PSRO. (A.408-409; 1408). The PSRO began auditing Petitioner's charts (A. 459) and continued reviewing his charts through 1981. (A. 518-519; 1418-1430).

In May of 1978 the PSRO held a hearing on Petitioner's charts. (A. 520; 1425). Petitioner had taken some courses from Dr. Gershon Efron of Baltimore,

professor and chief of surgery at Albert Einstein Hospital, associated with Johns Hopkins. He took the charts to Dr. Efron who wrote a detailed letter to the PSRO and introduced Petitioner to Dr. Ross Pierpont, chief of surgery at Maryland General Hospital. Pierpont reviewed the charts and called Cantey of the PSRO. (A. 460-462; 532-534). Cantey testified that he and Pierpont were friends:

> Q. Do you recall--are you acquainted with Dr. Ross Pierpont?
> A. Certainly, known a long time.
> Q. How are you acquainted with Dr. Pierpont?
> A. I was interested in the Southeastern Surgical Congress organization of about 2400 surgeons and I became president of it later, but Ross Pierpont came to meetings regularly from Baltimore, we Baltimore, we became friends. He has good credentials.
> Q. And do you recall receiving a telephone call from Dr. Pierpont around 1978?
> A. You asked me that earlier. I don't recall it, but I'm sure

that he says we had it, we had it. I don't recall any of the contents of it. I would I would assume, since he is here today, that it was related to Dr. Toussaint. What I said, what he said to me, I can't remember. You might be able to refresh my memory on something he or I said.

Q. In 1978, had you reviewed these charts, the charts that the audits were being conducted on?

A. Did I review them? Yes, ma'am, I'm sure I did. I reviewed an awful lot of them. (A. 523) (emphasis added)

Pierpont recalled the conversation with Dr. Cantey and testified that Cantey had not reviewed the charts.

Q. Tell me what happened when he got there?

A. ..... He came over and that is the first time I saw Dr. Toussaint and he had a bunch of charts with him, and he went--told me he was having-- I tell you what he told me? This is what we--the essence--

THE COURT: Go ahead, he was having trouble.

A. Here were charts that were under review and he was under the gun and would I review them from the standpoint of what the problems were with regard to them. I did so. Took a little while because there were a number of them. When I got

finished with him, I'm going to be very candid with you and tell you what I told him, which I think may be the essence
of some of the reasons why we're here. I said, "Dr. Toussaint, from a very short time knowing you, I think that ay (sic) be aggressive surgeon, don't see anything wrong with that, and I think you're a pain in the rear to a lot of people." And I said that is an immediate impression, but I don't see any reason why you should be under the gun for these charts that I'm looking at. And he said, "Well, can you help me at all?" and I said, "Well, as a matter of fact, I can, perhaps I can, because I know Bill Cantey, who heads that organization." I've known him for sometime in Southeastern Surgical and has been president and I'll call him up and see what we can do. And I remember the conversation very well. And so I called him up and it was how is the boy and how is everything and we got in conversation and that I said to him, "Do you know Vincent Toussaint" and the answer came back, "He's a bad apple".

* * *

A. And he said, "He's got to go". I said I don't understand what you are telling me. I said I've been over these charts that he is being questioned about and I don't really see anything wrong with those charts. He said--

and I asked him if he had been over those charts very specifically. The answer was, "No, but my boys got him dead to right, and I trust my boys and they got him dead to right." I said, "Wait a minute, Bill." He said, "You're not going to get involved in this are you Ross?" Said, "You're going to get hurt." And at that point I had to advise my old friend, Bill, to look out for himself and not to worry about me. I was all right and hoped he was all right. At that point, I said, "Bill, have you looked at those charts?" And again the answer was no. I said, "You better dam sight look at those charts; they do not sustain what you're trying to sustain in my opinion and in the opinion of anything I have done in this state." So, he said all right he would do that and that was the end of that. I didn't hear anymore about this. I thought it was gone, and then I got a frantic call. I guess that's when you were going to hear the case about a thing was brought up here today and that's what began to register in my mind, and I'm glad the barrister out there introduced the word today conspiracy because I didn't want to bring that up. It began to enter my mind that such was occurring. As I listened to these things, and I said, well-- remember, I didn't ask to get in this thing at all, but I think

> that I've always been interested in seeing that things get done properly, justice is served.... (A. 533-535).

In 1978 the operating room head nurse submitted complaints against Petitioner which included: not scrubbing long enough, drinking coffee in the operating room, putting his finger in a patient's throat to stop bleeding, leaving to get a pathologist and then regowning and regloving but not rescrubbing and swearing in the operating room. (A. 463) Neely was temporary administrator for a week, and he submitted the complaints to a committee which censured Petitioner for "disruptive behavior." (A. 237; 1723-1732). Petitioner attempted to leave Clinton. Dr. Walter Hastings of Spartanburg, S. C., was in poor health and asked Petitioner "to come over and help him with the idea of taking his practice".

(A. 463). Petitioner had temporary privileges at Doctors Memorial Hospital in Spartanburg. Hastings became ill, and Petitioner's temporary privileges ended. (A. 466) Dr. Lawrence Hurst who was chief of staff at Doctors Memorial Hospital in 1978 testified that Petitioner submitted an application for privileges at that hospital which he investigated. Hurst asserted that information concerning the investigation was privileged (A. 258-259) and that the standard procedure was filling out an application; granting temporary privileges, particularly if practicing with another staff member; processing the application which includes writing for references, verifying credentials and contacting the hospital at which the applicant practices. (A. 262). He testified that there were no problems with Petitioner which would have

prevented granting privileges:

> Q. Dr. Hurst, did you have any problem with Dr. Toussaint with his treatment of patients while he had temporary privileges at Doctors Memorial?
> A. Nothing of significance, nothing would have kept us from granting him privileges.
> Q. Did he perform operations while on the staff?
> A. Yes.
> Q. Did he admit patients?
> A. Yes, he and Dr. Hastings together.
> Q. Do you know approximately how many operations he performed while he was down there?
> A. I understand in the range of 20.....(A. 265-266).

Petitioner withdrew his applications for privileges at Doctors Memorial Hospital and Mary Black Hospital in Spartanburg. (A. 703-705; 929-936).

Dr. Roy Suber became chief of staff at Bailey Memorial Hospital in 1978, (A. 421-423) and was interviewed by an investigator for the State Board of Medical Examiners investigating Petitioner:

Q. Did y'all make referrals to board-certified surgeons from your practice?
A. Yes, ma'am, I did.
Q. And were the surgeons you made your referrals to Dr. Baker and Dr. Brockington in Greenwood?
A. It varied. I referred patients to the surgeons that I thought could do the best job for the procedure that was indicated.
Q. Dr. Suber, were you interviewed by an investigator of the State Board of Medical Examiners in 1978?
A. You sent me a copy of the report by a man that you said interviewed me; and I don't recall it.
Q. Are you saying he did not interview you?
A. No, I'm not.
Q. Do you recall any of the information contained in that memorandum?
A. Yes, ma'am, it summaries (sic) my feelings probably at that time.
Q. Can you tell us what your feelings were then at that time, if you would like?
A. Regarding what?
Q. Regarding Dr. Toussaint and information reported in that memorandum?
A. This is a memorandum which is dated November 27, 1978. And it's written by Investigator Richard Hodges, who I assume, you want me to read it.
Q. No, sir, I want you to tell me

if that reflects your feelings, or what your feelings were at that time?

A. This man apparently, I recall was sent to me as chief, while I was chief of staff to find out what the situation in regard to Dr. Toussaint was. Apparently the State Board of Medical Examiners was conducting an investigation of Dr. Toussaint.

Q. Had the complaint with the State Board of Medical Examiners been filed by the Laurens Hospital?

A. I don't know who filed it; I did not. I told him, according to this, and it was my feeling at that time, we had had reports of the audits, as having become part of this record, that certain procedures had been done that were not indicated. I had talked to Dr. Toussaint; he had, I thought, improved considerably, as indicated by the memorandum which I wrote, requesting that he be taken off review. Dr. Toussaint could be a very, very pleasant fellow. His patients love him. He had many good patients, he had many patients that thought very much of him. And yet, he just could not conform to regulations. There were constant complaints from all the departments of the hospital. You recall in yesterday's testimony, there was conflict about vascular surgery. On a Sunday evening at 9:00 o'clock, operating room supervisor called me at home and said Dr. Toussaint had scheduled

a cardiectomy for 8:00 o'clock on Monday morning. Bailey Memorial Hospital was not equipped to do vascular surgery. He had not set aside any blood. There was no one in the operating room experienced enough to scrub with him. The floors were not set up for followup care. There was no backup, and so I cancelled the surgery. Then there were appeals and there was quite a bit of confusion. There were many reports during this period of time. I talked to Dr. Toussaint on several occasions personally. He would say, "I'm going to do better", and he would for awhile, and then things would just get out of hand again.

Q. Dr. Suber, did you report to the investigator for the State Board of Medical Examiners that Dr. Toussaint was a constant source of trouble?

A. Yes, ma'am. (A. 422-424).

* * *

Q. Did you tell him that Dr. Toussaint had done a lot of operations that were not necessary in your opinion?

A. I said that based on the audit which is a matter of record.

Q. And did you tell him that Dr. Toussaint had done more hiatal hernia operations and splenectomies that you'd ever seen?

A. That's correct.

Q. Did you tell him Dr. Toussaint's patients were very fond of him?

A. I did.
Q. And when you tried to refer those patients to Drs. Baker and Brockington in Greenwood, patients wanted to go to Dr. Toussaint?
A. Let me phrase that this way. When I told a patient they needed surgery, they said, "Well how about Dr. Toussaint?" I felt that it was my responsibility, as their attending physician, to send them to the best man that I knew to do that type of procedure. And I found it very difficult over and over to say, "I don't think Dr. Toussaint is the man for that surgery." And that is what I meant by that.
Q. Did you say that when you tried to refer the patients to Drs. Baker and Brockington in Greenwood, they wanted to go to Dr. Toussaint, did you report that to the State Board investigator?
A. Lady, I can't remember ten years ago the exact words I said. I'm not sure I said those exact words.
Q. So you think that part of the memorandum is incorrect?
A. Yes.
Q. Did you tell those state board investigators that you found it difficult to tell patients you rather not send them to Dr. Toussaint?
A. Yes.
Q. Did you relate that Dr. Toussaint was extremely well liked by his patients, and

spends a great deal of time with them?

A. I testified to that.

Q. Did you relate that he spends a great deal of time with his patients in the hospital?

A. I don't recall.

Q. Was that true at that time?

A. Yes, I think so.

Q. All right. Did you relate to the state board investigator that Dr. Toussaint helped--goes to patient's room, helps load them on a stretcher and takes them to the operating room?

A. Yes.

Q. Did you relate he follows his patients closely in the hospital?

A. Now that I don't remember.

Q. Are you saying you didn't say that?

A. No.

* * *

Q. At that time did Dr. Toussaint follow his patients closely in the hospital?

* * *

A. I'll say yes. (A. 425-427)

In 1979 Suber wrote to the PSRO requesting that Petitioner and other and other staff members be exempted from PSRO review because of "good performance in compliance with PSRO norms and standards." (S. 420-421) Baker testified that in 1977 he was getting a

number of referrals from Laurens County including vagotomies and still gets a number of referrals from Laurens. (A. 413-414).

In 1980 Petitioner returned from vacation and was verbally notified that he was suspended from the hospital staff. He requested a hearing. Two days before his planned vacation he had admitted a patient with abdominal cramps for observation and diagnosis, told the patient he would be going on vacation, had ordered X-rays and transferred the patient to Dr. Arscott's service. Dr. Arscott who was a general practitioner diagnosed a partial small bowel obstruction and referred the patient to Respondent Marshall, a surgeon, who had moved to Clinton about 1979. Marshall operated and removed a "very rare tumor". The patient did well,

but Marshall complained to the chief of staff, Walker's partner. A hearing was held a couple of days and Petitioner was reinstated. (A. 205; 452-472; 1160-1162).

In 1980 Petitioner was served with a State Board of Medical Examiners complaint which contained the "exactly identical complaints" that were made by the nursing staff in 1978. The complaint was amended in 1983. (A. 472-473; 1145; 1723-1732). That complaint also referred to charts that had been reviewed and criticized by the PSRO. (A. 1146-1148; 1425-1429).

In 1981 or 1982 Petitioner met with the PSRO. The PSRO recommended to the Department of Health and Human Services that Petitioner be sanctioned. In 1983 the Department of Health and Human Services instituted and published a sanction. Pierpont was contacted,

reviewed the additional charts, found nothing wrong and agreed to testify at the de novo adversarial appellate hearing. A settlement was reached whereby Petitioner dismissed his appeal of the sanction and released the Department of Health and Human Services, its agents, employees and consultants from liability for their investigation, prosecution and sanction whether within or without their official duties and for actions alleged to be malicious or unlawful, and the Department of Health and Human Services voided the sanction from its original effective date. (A. 474-475; 524-526; 531; 536; 1154-1158).

In 1982 Walker's partner notified Petitioner that an incident report had been filed by a nurse regarding Petitioner's reluctance to examine a "service OB patient" in the emergency

room and the language used in addressing the nurses, and that the executive committee was taking the following action: officially reprimand for abusive behavior, ordering an apology to the nurses and instructing Petitioner that because he had general practice privileges he was to examine any service obstetrical patient in the emergency room and to make disposition of the patient. (A. 1722).

Petitioner's hospital privileges were suspended in July 1983, and he employed John Ferguson, a lawyer and resident of Clinton. Ferguson testified that about July 6, 1983, prior to a hearing before the hospital board he was in Respondent Ham's office, the hospital administrator, and Respondent Emerson, who was chairman of the board, and Marshall were there. Ferguson testified that his conversation with the three

respondents was an attempt to see if there was some way that the "continuing" situation might be resolved. All three respondents expressed exasperation in dealings with Petitioner, and the respondents discussed that something had to be done. Ferguson expressed his concern that the matter would end up in court because of "procedural difficulties" and "violation of due process". (A. 245-246; 249-252).

Mr. Ferguson testified:

> BY MR. LITTLEJOHN:
> A. ....Dr. Marshall stated that if it had to go to court, then it would just have to go to court, because, again something had to be done. And he mentioned to me that he, or that in some fashion the operating room, the head, either head of the operating room nurses or head of nursing staff was scrutinizing the activities or surgery of Dr. Toussaint with the idea of seeing what his activities were and perhaps accumulating data should further action be necessary against Dr. Toussaint.

Q. And who made that statement to you, Mr. Ferguson?
A. That was Dr. Marshall.
Q. Who was present during the conversation?
A. That would be Clem Ham and Russell Anderson (sic) (Emerson) as well as myself.
Q. Now was this prior to a hearing was held in this matter?
A. Immediately prior to a hearing.
Q. Just for clarification, when was settlement,
when did that take place, was
A. Settlement was after the hearing. I think maybe the day after the hearing, there was an oral agreement to a settlement which was ratified by a written agreement a few days later.

* * *

BY MR. TURNER:
Q. This took place, I believe you said July 7 or July the 5th. somewhere around in there?
A. Probably about the 6th?
Q. All right. And do you recall the release which was signed?
A. Yes, I do, I do believe this is a copy of it.
Q. And what is the date of that release?
A. July 13, 1983.
Q. So this was some week or 7 days--the release was signed after this conversation?
A. That's right.
Q. Now, Mr. Ferguson, in your representation of Dr. Toussaint at that time, do you recall whether or not Dr. Toussaint was charged with having violated any

rules or participating in disruptive behavior in the hospital?

A. The charges dealt originally with a, well charges began with a letter from the head of nursing, and a week later the head of the operating room nurses also put in a letter, and both these letters stated that Dr. Toussaint had been disruptive, undiplomatic to the nursing personnel.

Q. In fact charges were he was harassing the nurse, isn't that correct?

A. I think that the, that was tenor of some of the accusations, that's correct.

Q. And that he was violating some of the rules in the operating room, and he was violating rules in other places, is that correct or not?

A. There were general allegations to that effect.
The two letters were not particularly specific, except the letter from the operating room nurse had attached to it a number of perioperative unusual occurrences.

Q. Did you not tell me in deposition that perhaps Dr. Toussaint has (sic) been cavalier with the rules at that time?

A. It is possible that he was. I wasn't present. I do know that was the accusation that was made against him.

Q. You reviewed it though, didn't you?

* * *

A. That was the accusation that was made against him at the time. And as far as a strict adherence to the rules, as I recall, and it has been four years, I think there were some discrepancies, but I also seem to recall, Dr. Toussaint had not been provided with a copy of the rules prior to this.

Q. You mean surgical rules?

A. Again, it has been four years, some rules, whether they were hospital rules, whether they were surgical rules, it is my recollection he had requested a copy of the rules and had not be (sic) provided with them. (A. 253-256).

The release stated that Petitioner was suspended from July 4, 1983, to July 17, 1983, that the suspension had been nullified on appeal and that Plaintiff released Laurens County Health Care System, its agents and all persons from liability. (A. 1721).

The State Board of Medical Examiners' complaint against Plaintiff which was served in 1980 and amended in 1983 was dismissed. (A. 473; 933-934;

1142-1149).

Jan Lever testified that she and her children are patients of Petitioner who suggested that she take her children to Respondent Ramsay, a pediatrician, that Ramsay asked her to write a letter criticizing Petitioner's care of her family and stated that he would take it to "the hospital or the people who needed to read it", that Ramsay asked her about writing such a letter everytime she saw Ramsay or called him and that Ramsay called her on several occasions to ask her to write the letter which she "couldn't in all honesty write", and that because of Ramsay's calls she had her telephone number changed. (A. 267-271).

On April 22, 1986, Petitioner was summarily suspended for reviewing the hospital chart of a child, Demontre Grant. Ramsay was out of town and had left the child in the care of Dr. Ronald

Pudlo. Pudlo was contacted by Petitioner on Saturday, April 19, 1986, told that the child's mother had asked Petitioner to review the chart and consented to the review. Barbara Grant, the mother, testified that she contacted Petitioner, asked him to review the chart because the child had been sick for many months, had not improved under Ramsay's care, and that Ramsay had instituted an action against her in the Family Court through the Department of Social Services. Dr. Richard Carter, an Otorhinolaryngologist in Greenwood, testified that he had examined the child. Carter was contacted by Petitioner and recommended transferring the child to Charleston to a pediatric surgeon because of a grossly infected mastoid. Ramsay returned on April 21, 1986, and Petitioner attempted to discuss the child's transfer on two

occasions. Barbara Grant signed two statements in attempts to get Ramsay to release the child. Ramsay ordered that the child not be removed from the clinical area at the hospital. After a hearing in the Family Court the child was sent to Charleston where his mastoid was surgically removed and he was diagnosed as suffering from tubercline lesions of the brain and a neoplasm. South Carolina Law Enforcement Division agents asked the mother if she had signed the statements requesting that the child be transferred, and she told the agents she had. Clark had been treating the child since the child returned. Clark stated that he saw nothing wrong with Petitioner reviewing the chart at the mother's request and after obtaining Pudlo's consent and saw no reason for a summary suspension. Clark also testified that the child needed treatment for tuberculosis and

that the transfer of the child was appropriate. Ramsay complained on April 21, 1986, that Petitioner had reviewed the chart without authorization. Emerson testified he ordered Ham to summarily suspend Petitioner. Under the medical staff by-laws the administrator may only impose a summary suspension "when action must be taken immediately in the best interest of patient care in the hospital." Petitioner met with an ad hoc investigatory committee and presented statements from Pudlo and Barbara Grant. Emerson instructed Marshall to lift the suspension after Emerson met with Petitioner's lawyer who told Emerson that he did not have authority under the medical staff by-laws to lift the suspension he had ordered imposed. (A. 475-485; 341-350-358; 823-824; 831-832; 1163-1174; 1334-1335; 1508; 1650-1660).

Petitioner sued the board for expenditure of public funds in a compaign. In the summer of 1986 Emerson told Petitioner "to get with the team or get off it", and he wrote to Emerson and objected. Emerson responded and asserted that there was no orchestration of complaints. (A. 575-576; 827-828; 1177-1180).

In September 1986 there were several complaints against him. He was accused of being unavailable for emergency room call on August 27, 1986. He told the committee that Dr. Raheja had agreed to cover his patients, that he was out of town and arrived at the emergency room approximately thirty minutes after he was called, but the statement was excluded from the minutes. Later Ramsay notified him to respond in writing by September 15, 1986, or he would be suspended. Thereafter, the executive committee

notified him that they had reviewed a report from the emergency room committee and decided he was at fault and that a repeat offense would result in immediate and strict disciplinary action. He was never asked to meet with the executive committee. (A. 578-582; 1181-1183). Ramsay notified him that the pediatric committee would investigate a complaint by nursing of inadequate and inappropriate orders. He met with the pediatric committee. Later he was notified that the executive committee was placing a restriction on his privileges related to newborns which prohibited him from treating newborns but was not invited to meet with the executive committee. He requested a hearing which was scheduled when he was to take his American Board of Surgery exam for recertification. The hearing was continued and never

rescheduled. Ham testified that the reduction in privileges never went into effect, but Petitioner was never so notified. (A. 214-215; 582-590; 1185-1193; 1237-1238).

The medical staff by-laws provide that before there can be reduction or suspension of privileges, except a summary suspension, there must be: written request for corrective action, an ad hoc committee interview and investigation, an executive committee review and interview, an adversarial hearing before an ad hoc committee with the executive committee as adversary, review of the decision by the executive committee and appellate review by the board of directors. (A. 1506-1520).

In October of 1986 there were several more complaints. Ham accused Petitioner of distributing a tracheotomy kit, a hospital supply. He had a patient

in the hospital who had had a tracheotomy. His office is attached to the hospital. When he examined the patient a tracheotomy kit was not available. A nurse got a tracheotomy kit and brought it and the patient to his office. (A. 1200-1203; 599). Ham accused him of removing thirty charts from the hospital. The thirty charts were in the surgical suite in the hospital where dictating equipment is provided. (A. 595-596). The director of nursing notified him that he would no longer be notified when a chart was incomplete because he was rude. (A. 593-595). Ramsay directed that a charting complaint be made against him. (A. 604-608; 1204-1207). The executive committee notified him that he had not returned the tape recording or provided minutes of a staff meeting and that if he did not immediately deliver the tape, his

privileges would be suspended. (A. 608-610; 1208). The director of nursing complained that a patient in critical condition was admitted from a physician's office without prior notification or orders. Apparently the patient arrived shortly before the orders. The complaints were delivered by courier to him. (A. 610-612; 1209). He was accused of doing a colostomy without consent. Sara Pittman and her husband testified that they were both fully aware that a colostomy might be done. (A. 276-284; 1228-1230; 1242). He met with an ad hoc investigatory committee which included Dr. Roger Jinkins investigating the justification for three mastectomies performed by him on teenage boys with gynecomastia based on a complaint by the director of nurses and was notified that the executive committee had suspended his privileges for thirty days beginning

November 17. He had not met with the executive committee. (A. 615-632; 1211; 1220; 2201-2202; 1235-1238). He was accused of removing fourteen charts from the hospital. He did not remove the charts and did not know who removed them. Two weeks later he discovered the charts in his locker in the surgical suite and does not know who had put them there. (A. 612-615).

In November 1986 there was another suspension and complaints. Ham complained that a patient had been admitted to Petitioner's service, had been discharged and died within twelve hours after discharge. The executive committee summarily suspended his privileges for thirty days beginning December 17. The patient admitted for a scalp laceration and alcohol intoxication, protested being in the hospital and died as a result of a

sickle cell crisis probably induced by alcohol consumption after she left the hospital. A nurse reported that he instructed her to discharge the patient over the telephone which she said was unusual, but she did not call him back to clarify the order. He denied discharging the patient and the patient's daughter's affidavit stated that the nurse told her after the telephone call that if her mother did not be quiet she would have to leave. (A 927, 1231-1239; 1733-1735, 1836, 1852, 2973-2998-3011-3012).

Dr. Holbrook Raynal notified him that he was investigating alteration and/or falsification of a chart and invited him to meet with the record and tissue committee. The director of nursing had complained that he entered a date on the chart indicating an examination on the date of the child's birth but that he did not examine the child. The

child's mother and grandmother testified that they saw him examine the child. He had inadvertently failed to enter the date by the examination and later went back and entered the date. (A. 300-305; 639-641; 1240-1276). Mrs. Glenda Dominick was hospitalized in November and was told that he had been suspended and that she would have to leave. Nurses made derogatory remarks to her about him. She stated that she had been ill for some time, had been treated by several doctors but he had done more for her than any other doctor. (A. 291-298).

Respondent Young statedied in deposition testimony on two separate occasions that Respondent Culbertson had stated at a board meeting that Petitioner should go elsewhere but recanted his sworn testimony. (A. 361-363).

In February 1987 Marshall wrote to

the surgical committee stating that David Samples and his wife had been to his office and complained that Petitioner discharged Mr. Samples from the hospital too soon. Affidavits were submitted to the committee from nurses stating that the Samples had complained and that Mr. Samples had not taken liquids by mouth. The Samples testified that Mr. Samples was ready to go home, that he had been drinking water and eating ice, and that they had not complained. Mr. Samples could not recall having ever been to Marshall's office. Mrs. Samples had not been to Marshall's office in over four years but stated that Marshall called her and asked if she was satisfied with her husband's care and stated that she had been to his office. She informed Marshall that she had not been to his office. Because Petitioner stated that Mr. Samples had consumed clear liquids by

mouth prior to his discharge, the surgical committee questioned his honesty and integrity. (A. 553-559; 562-569; 1412-1416).

In 1987 the peer review proceedings were reinstituted on the suspensions imposed in November 1986 following an Order of the District Court. Petitioner objected to certain members of the ad hoc investigatory committee on the basis of expressed prejudice and objected to the members of the executive committee. He was given a list of alleged factual allegations. He requested a statement of the rules or standards violated. He was notified of vague offenses such as: committing a serious offense; providing inadequate and inappropriate care; deviating from the by-laws which vaguely provided that he was to insure a high level of professional performance; to

adhere to the ethics of the profession; and obligated to provide continuous care and supervision of patients. The ad hoc investigatory committee and the executive committee recommended suspension. The ad hoc hearing committee dismissed all charges pertaining to admission and treatment of Sallie Hunter, but found a violation in the charge that the patient was allegedly discharged without being examined and stated that examination of a patient prior to discharge is a generally accepted standard which might have resulted in an allegation of negligence had there been harm to the patient. There were extreme and opposing differences of opinion and no consensus among the physicians who testified as to whether such an alleged discharge was proper or improper. The hearing committee imposed a suspension of 60 days with credit for time served in 1986 but

there was no allegation that the patient was harmed by the alleged discharge. The ad hoc investigatory and executive committees on the mastectomy cases initially charged that the procedures were not justified because of the absence of documentation of numerous workups not required by the hospital, but all of the physicians who have done the procedure testified that they do not do the workups and that after reviewing the charts they concluded that the procedures were justified. The hearing committee found that the charting was poor and below generally accepted but unspecified standards and recommended probation and monitoring to include medical record review with emphasis on completeness of history and physical, justification for surgery and agreement of pathology report and admitting diagnosis. The committee

did not find specific deficiencies in the histories and physicals and found that the procedures were justified and the patients benefited. The admitting diagnoses and pathology reports agreed and the committee did not find otherwise. The executive committee which included Jinkins, a member of the ad hoc investigatory committee of 1986 on the mastectomies, reviewed the decision and affirmed. The board of directors affirmed after Petitioner asked that Respondents Emerson, Walker, Corley and Culbertson recuse themselves. Walker was absent. Emerson, Corley and Culbertson recused themselves from the final vote but deliberated. The board criticized him for making additions to his office records in the gynecomastia cases, but the affidavits and testimony of the patients and their families corroborated the office records. (A. 2401-2488; 2200-

2401; 3025-3069; 2551-2608; 1754-2199; 3005-3014; 2999-3004; 2489-2528; 2529-2546; 2864-2914; 2547-2550; 322-339; 491-511; 3072-3119; 991-992; 829; 843-848; 2037-2080; 2306-2307; 2242-2245; 2248-2249; 2252-2255; 3005-3010)

From 1976 until November of 1986 he averaged more admissions than any other physician. The 1986 suspensions received widespread publicity (A. 378-397; 1336-1401) and since his monthly admissions have been reduced from an average of 35 to 12 (A. 1003-1095) while surgical procedures have been reduced by half. (A. 786-788)

The Joint Commission on Accreditation of Hospitals requires that physicians be evaluated by objective predetermined criteria. (A. 1119-1141) Article I, Section 3 and Article II, Section 1 of the by-laws of the Laurens

County Health Care System gives the board of directors complete authority to operate the hospital. (A. 1570-1571) In Article VI, Section 2 the board delegated the authority to regulate and set policy for the medical staff to the medical staff. (A. 1591-1592) Emerson testified that the board has final authority to set goals or policies for the system and that in carrying out those functions the board makes decisions between alternatives. (A. 830)

ARGUMENT

This case exemplifies why this Court should define the requirements of both substantive and procedural due process in medical disciplinary situations, an area in which there has been diversity of rulings in state and federal appellate courts.

1. The trial court erred in that the findings of fact are clearly erroneous.

This issue is inextricably linked to the second question presented. Petitioner seeks to have this Court define what must be proven to sustain a cause of action for violation of 42 U.S.C. 1983 in such a situation. The Court of Appeals, without addressing this issue, concluded that the 1986 suspensions were the "real subject" of this action, that procedural due process was observed and that the "claim of violation of substantive due process is premised on the contention that the standards under which the decision to suspend...was made 'were impermissibly vague and arbitrary/non-existent'" and cited Sosa v. Board of Managers of Val Verde Memorial Hospital, 437 F.2d 173 (5th Cir. 1971) as authority that a hospital need not prescribe exact rules governing of medical care with precision and exactness.

Actions by Respondents and others over the years have severely damaged Petitioner. Reduction or suspension of privileges may severely stigmatize a physician and deny him future employment. Paul v. Davis, 424 U.S. 693, 711-712, 96 S.Ct. 1155, 1165, 47 L.Ed.2d 405 (1976). Christhilf v. Annapolis Emergency Hospital Association, Inc., 496 F.2d 174 (4th Cir. 1974) defined five procedural necessities in such a situation: (1) reasonable notice of the charge, (2) adequate time to prepare, (3) the right to present evidence, (4) the right to rebut evidence, and (5) the right of cross-examination. Not until 1987 when proceedings were reinstituted on the November 1986 suspensions were these procedural safeguards afforded.

In United States v. United States Gypsum Company, 333 U.S. 364, 68 S.Ct. 525, 92 L.Ed. 746 (1948) this Court

reversed the findings of the trial court as clearly erroneous and found that a conspiracy was proven. Holding that pursuant to Rule 52 of the Federal Rules of Civil Procedure a finding is "clearly erroneous" when although there is supporting evidence the court is left with a definite and firm conviction that a mistake has been made. In Baumgartner v. United States, 322 U.S. 665, 64 S.Ct. 1240, 88 L.Ed.1525 (1944) this Court agreed to review the case to rule on what was required to be proved in such a deportation situation and referred to findings of ultimate facts which imply the application of standards of law. See also: Pullman-Standard v. Swint, 456 U.S. 273, 286, n.16, 102 S.Ct. 1781, 72 L.Ed.2d 66 (1982). The trial court has made "findings of fact" such as petitioner was afforded "due process" or

granted a "hearing" based on application or misapplication of legal standards which are mixed questions of fact and law or legal conclusions.

2. The trial court erred in concluding that Petitioner failed to sustain his causes of action for violations of 42 U.S.C. 1983.

The Court of Appeals affirmed the ruling of the trial court based on the holding that Sosa v. Board of Managers of Val Verde Memorial Hospital, 437 F.2d 173 (5th Cir. 1971) is authority that the law does not require hospital staff to prescribe exact rules and has been cited as precedent in Klinge v. Lutheran Charities Association, 523 F.2d 56 (8th Cir. 1975). Sosa followed a ruling by the Florida Supreme Court in North Broward Hospital District v. Mizell, 148 So.2d 1 (Fla. 1962) which held that detailed description of prohibited

conduct is impossible because a human life may be involved.

However, in Milford v. People's Community Hospital Authority, 380 Mich. 49, 155 N.W.2d 835 (1968) a physician was disciplined under bylaws which provided that privileges may be reduced if "to the best interest of the hospital and its patients" and may be revoked for "violation of any of these bylaws, unprofessional conduct, malpractice or unethical practice" 1555 N.W.2d 838. The Michigan Supreme Court held the bylaw did not meet due process requirements and rejected the holding in North Broward Hospital:

> We then turn to the provisions of the bylaws in the case at bar where a physician may have his privileges reduced if in the opinion of the committee it appears that a reduction would be "to the best interest of the hospital and its patients". What is in the best interest of the hospital and its patients? The only possible answer to this question is: anything that the executive committee in its sole opinion decided would be for the best interest of the hospital and its patients.

The bylaws in question provide no qualifications which the staff physician must possess, provide no standard of knowledge or skill, nor do they make any provision as to the character or conduct of the physician. They, in fact, attempt to confer upon the executive committee the arbitrary power to reduce privileges according to their whim or caprice, subject only to appeal to the staff and ultimately to the board, whose powers of review are equally arbitrary. "Under all the authorities, we think this cannot be done." Devereaux v. Township Board of Genesee Township, 211 Mich. 38, 43, 177 N.W. 967. See, also, cases therein cited.

Defendants and amicus curiae rely almost entirely upon the case of North Broward Hospital v. Mizell (Fla. 1962) 148 So.2d 1, which approved a bylaw adopted pursuant to a statutory delegation which authorized the board of commissioners of public hospitals to see that "the welfare and health of patients and the best interest of the hospital may at all times be best served." The governing board of the hospital adopted the following bylaw:

> "The board of commissioners reserves the right to remove any member of the medical staff or to deprive any physician or surgeon of the privileges of the hospital whenever in their sole judgment the good of the hospital or the patients therein may demand it."

This Court, however, has failed to go that far in any of its decisions, and the defendants in the case before us have failed to present any justification for so doing.

We agree with the Court of Appeals in

> its holding that there are absolutely no standards in these bylaws which would meet the constitutional due process requirements. 155 N.W. 2d 841-842.

Sosa and North Broward Hospital fly in the face of federal statutes and regulations which set out specific "norms" to evaluate quality of treatment of medicaid and medicare patients, 42 U.S.C. 1320c-5, and the requirements since 1985 of the Joint Commission on Accreditation of Hospitals that physicians be evaluated by objective predetermined criteria (A.119-1141) and with federal regulations for hospitals licensed to receive medicaid and medicare funds which require compliance with rules for handling telephone orders from physicians 42CFR482.23(2)(i) and the National Code for Nurses adopted by statute in South Carolina which requires that a nurse who receives a "questionable" order inform the physician that she deems the order questionable. Section 40-33-930 Code

of Laws of S. C. (A. 2899)

Without notice of what specific conduct is prohibited and by what standards he will be judged, a physician is vulnerable to being evaluated based on subjective and arbitrary criteria and may be arbitrarily disciplined based on extraneous motivations.

Clearly, hospital have enacted specific standards and rules. Dr. Ross Pierpont who was associate professor of surgery at the University of Maryland, chief of surgery at Maryland General Hospital for 28 years, on the Review Board of Health for Maryland for 12 years and the Maryland Board of Hospital License for 8 years (A.2007-2008) testified at the 1987 proceeding before the ad hoc hearing committee:

Q. The gynecomastia cases and Sallie Hunter. Did you find in your review of those charts any violation of any standard of any medical care?
A. There is no standard...You have to

write it down in your bylaws, and you have to write it down in every department, and you have to say what you want people to do. You really don't have any real standards to measure anybody by...We've had to do it over and over again through the years as they've altered the proposition, we've had to down the line and alter the proposition...If you came before the Maryland Board of Hospital Licensure, we wouldn't license you...

Q. When you served on the Maryland Hospital Licensure Board, did you require that hospitals have standards and criteria by which to evaluate---

A. Absolutely. Absolutely...Maryland has been, I guess, in the forefront of licensing and all the rest of it for many years. We've got Hopkins in Maryland there...they've been in the forefront of this, and so we have. And they've had a great influence on the legislature and the governor of that state, and so they have basically set the patterns...(A. 2010--2012)

* * *

Q. --Developing criteria and reviewing physicians and things like that, do you see anything on the Sallie Hunter case or on the gynecomastia cases that would justify imposing any sanction or discipline against Dr. Toussaint?

A. I have the problem again of what are we going to impose them, on what basis. We don't have any yardsticks. You don't have a yardstick to measure anything...You can develop your own criteria to fit you, but you have got to have something in writing, and I am surprised that the Joint Com-

mission doesn't raise sand about it.

Q. Is that criteria in writing, those rules and regulations, are they applied equally and objectively to everyone?

A. Our surgical rules are across the board. We have a surgical set of rules, ENT has another set of rules, opthamology has another set of rules. They come under the umbrella, the bylaws and the board, you see. It's an expensive nuisance, but it all must be there. (A.2025-2026)

The California and Kentucky Supreme Courts reached conclusions similar to Milford, but not on constitutional grounds and and recognized inherent danger in vague and ambiguous bylaws. In Rosner v. Eden Township Hospital District, 375 P.2d 431 (1962) the California Supreme Court held:

> Moreover, a hospital district should not be permitted to adopt standards for the exclusion of doctors from the use of its hospital which are so vague and ambiguous as to provide a substantial danger of arbitrary discrimination in their application... In these circumstances there is danger that the requirement of temperamental suitability will be applied as a subterfuge where considerations having no reference to fitness are present....375 P.2d 435.

In McElhinney v. William Booth Memorial

Hospital, 544, S.W.2d 216(1977), the Kentucky Supreme Court held:

> In this case, the hospital enacted specific regulations governing the suspension or termination of staff privileges. They provided substantially: Suspension: (1) gross professional incompetence or dereliction, (2) gross unethical or moral misconduct, (3) violations of hospital regulations and policies to such an extent that disciplinary action is deemed advisable. Termination: "Violation of sufficient gravity to warrant such action."...The express standards, vague though they be, do not condemn criticisms relating to treatment of patients or hospital practice nor do they proscribe inability to get along with some doctors or hospital personnel.
>
> * * *
>
> We hold that a private hospital, regardless of the breadth of discretion that may be extended to it, cannot revoke the staff privileges of a physician in the absence of a sufficiently definite standard proscribing the conduct for which revocation is adjudged. 544 S.W.2d 218

Rules which do not define standards of conduct endanger the accused physician and the public. Such vague rules allow good physicians to be arbitrarily and subjectively disciplined at the whim of their peers, and they also allow physicians

to be protected from disciplinary action based on subjective interpretation. Neither society nor the integrity of the medical profession is best served by decisions such as Sosa and North Broward Hospital.

Respectfully submitted,

Larkin Mims

Larkin Mims
&
Cameron B. Littlejohn
&
Randall M. Chastain

December 6th, 1988

A P P E N D I X

UNPUBLISHED

UNITED STATES COURT OF APPEALS

FOR THE FOURTH CIRCUIT

No. 88-3903

Vincent S. Toussaint, M. D.,

Plaintiff-Appellant,

v.

LAURENS COUNTY HEALTH CARE SYSTEM, and Russell Emerson, Edward M. Corley, Walter A. Sigman, W. Paul Culbertson, L. W. McClain, Michael R. Meeks, James L. Walker, Reese Young, James G. Ferguson, W. M. Wiley, individually and in their official capacity as members of the Board of Directors of Bailey Memorial Hospital, AND; CLEM P. HAM, individually and in his official capacity as Administrator of Bailey Memorial Hospital, AND; AKHTAR HUSSAIN, M.D., individually and in his official capacity as Chief of the Medical Staff at Bailey Memorial Hospital and as a member of the Executive Committee of Bailey Memorial Hospital, AND; BRUCE MARSHALL, M.D., individually and in his official capacity as a member of the Executive Committee of Bailey Memorial Hospital and as Chief of Service for Pediatrics at Bailey Memorial Hospital, AND; STEPHEN RAMSAY, M.D., individually and in his official capacity as a member of the Executive Committee of Bailey Memorial Hospital and as Chief of Service for Pediatrics at Bailey Memorial Hospital, AND; ARVIN RAHEJA, M.D.,

individually and in his official capacity as Chief of service for both Surgery and Obstetrics at Bailey Memorial Hospital,

Defendants-Appellees

Appeal from the United States District Court for the District of South Carolina, at Greenville. G. Ross Anderson, Jr., District Judge. (CA-86-3165)

Argued: July 25, 1988
Decided: September 7, 1988

Before RUSSELL, WIDENER and HALL, Circuit Judges.

Pamela Larkin Mims (Cameron B. Littlejohn, Jr., LEWIS, BABCOCK, PLEICONES & HAWKINS; Randall M. Chastain, UNIVERSITY OF SOUTH CAROLINA SCHOOL OF LAW, on brief) for Appellant. John Michael Turner (CULBERTSON, WHITESIDES & TURNER; C. Dewey Oxner, III, HAYNSWORTH, McKAY & GUERARD on brief) for Appellees.

PER CURIAM:

This is an action under 42 U.S.C. 1983, by a physician asserting a due process violation by a publicly-owned hospital for suspending his hospital staff privileges for a period of thirty days on two separate occasions. The case was heard by the district judge without a jury. The district judge made extensive findings of fact and stated conclusions of law. On the basis of these findings of fact and conclusions of law, he granted judgement in favor of the defendants. From that judgment this appeal is prosecuted. We affirm.

The plaintiff is a certified surgeon. Since 1976 he has resided in Clinton, South Carolina, and has been during all that time a member of the medical staff at the Bailey Memorial Hospital, then a publicly-owned and

operated hospital in Clinton known as the Bailey Memorial Hospital and now a part of the Laurens (County, South Carolina) Hospital County Health Care System (hereinafter Laurens), owned by Laurens County, a political entity of the State. During his years on the staff, he has had a number of disputes with the hospital and its medical staff over his acts as a member of the staff. Five of these disputes resulted in order of suspension of his hospital privileges for short periods of time and one an order of restriction placed on his medical activities in certain areas of the hospital. The first of these incidents was in January, 1981, when the staff privileges of the plaintiff and another physician were summarily suspended, an action which on appeal was lifted with a continuing admonition that the two should

"exercise greater care on future admissions to insure that the medical needs of the patients were being adequately met." The second incident in mid-July, 1983, involved a summary suspension, which was again lifted after a hearing followed by a release by the plaintiff of Laurens and all parties of any claim on account of this suspension. In April, 1986, the plaintiff was given a summary suspension which lasted three days. When plaintiff's appeal was heard, the suspension was lifted. This suspension arose out of a charge of another physician and staff member, complaining of an alleged unauthorized and unprofessional interference by the plaintiff in the case of a patient under the care of the complaining physician. There was also a complaint about the plaintiff's treatment of newborn babies. It was suggested that some restriction be

placed on the plaintiff in his treatment of new-born babies but this suggestion was never actually implemented. This review brings us to the two incidents, occurring in latter-1986, which led to the filing of this action and which are the real subject of the action.

The plaintiff performed, in November, 1986, three mastectomies on three teen-age males. It was charged that plaintiff had violated traditional medical standards of care in performing and reporting such operations. An ad hoc committee was appointed to investigate the charge. The committee had a hearing at which the plaintiff appeared and was heard. The committee recommended a 30 day suspension because the plaintiff had allegedly failed to conform with recognized standards of care and reporting. The plaintiff was advised of

this action.

About one month later, following an inquiry by the County Coroner, the administrator of the hospital filed a request for corrective action against plaintiff. The administrator's complaint involved a patient, Sally Hunter, who was admitted to the hospital with a head injury and in a heavily inebriated and boisterous condition. The plaintiff prescribed medication for the patient over the telephone but did not come to the hospital to see the patient. Later on the night of the patient's admission, a hospital nurse called the plaintiff about the patient's disruptive conduct. Without seeing the patient, the plaintiff directed the discharge of the patient. Several hours after her discharge, the patient died. The plaintiff was notified that a further suspension of 30 days would be imposed for this alleged

failure. The plaintiff at this point filed this action, and the suspensions under the two charges were never implemented.

The plaintiff has filed three complaints stating alleged violations of his substantive and procedural due process rights of the Federal Anti-trust Act, and of the Federal and State Trade Acts, as well as actions for business disparagement and libel and slander. The action was disposed of by the district judge on motions for summary judgment. In a carefully considered decision, he dismissed all the motions as without merit. The plaintiff has appealed that decision. At the hearing before us, he limited his appeal to the section 1983 action for violation of his substantive and procedural due process rights.

There is no dispute between the

parties that plaintiff's hospital privileges could not be suspended or terminated in violation of his substantive and procedural due process rights. Duffield v. Charleston Area Medical Center Inc., 503 F.2d 512, 515 (4th Cir. 1974); Christhilf v. Annapolis Emergency Hospital Ass'n., 496 F.2d 174, 180 (4th Cir. 1974). The plaintiff's claim of violation of substantive due process is premised on the contention that the standards under which the decision whether to suspend the plaintiff's staff privileges was made "were impermissibly vague and arbitrary/ non-existent." The Special Ad Hoc Hearing Committee, constituted under an agreement of the parties to dispose of the proposed suspension of October and November, 1987, stated clearly the standard it was applying:

Much has been said about

> Standards of Practice. The Committee accepts a definition of a Standard of Medical Practice as being that manner of care or degree of skill which would be rendered by a reasonable physician under the same or similar circumstances. To the members of this Committee, Dr. Toussaint has been charged with violating two standards of practice that are so basic to the practice of medicine, that it is unlikely anyone would bother to write them down, namely, every surgical procedure will be justifiable and appropriate and no patient will be discharged without being seen and examined by the attending physician.

Addressing the two incidents themselves, the Committee said with reference to the charges involving the mastectomies:

> It is our opinion, however, that evidence has been presented which shows that this is an operation whose indications vary considerably with different practitioners, is infrequently performed, and which has a high potential for abuse, and it is therefore incumbent on the surgeons who perform it to be meticulous in their

> record keeping, performance of a history and physical, and recording of any data by which the indications for and justification of a procedure will be evident to any peer review group. This is amply supported by the Accreditation Manual for Hospitals of the Joint Commission on Accreditation of Hospitals, 1986. (See Medical Record Services, 9.2, 9.2.1.2, 9.2.2.3, 9.2.2.2.1-4, 9.2.2.3.1, 9.2.2.3.5).

Reviewing the second incident involving the Hunter discharge, it said:

> Relative to Sally Hunter, the committee finds no evidence to support violation of standards related to her care in the emergency room, admission or admission orders.
>
> It is our opinion, however, that evidence presented to us supports the charge that Dr. Toussaint knowingly discharged Ms. Hunter from the hospital without having seen or evaluated her in any way, that this is a violation of a very basic standard of medical care, and could be construed as negligence had there been any allegation of harm to the patient as a result of her manner of discharge.

The district judge, after fully canvassing the evidence, found that these standards followed and applied by the Committee met the requirements of substantive due process in the context of staff hospital privileges. After all, the law, as the district judge held, does not require the hospital staff to prescribe exact rules covering all phases of medical care with precision and exactness. This was declared authoritatively in Sosa v. Bd. of Managers of Val Verde Memorial Hospital, 437 F.2d 173, 177 (5th Cir. 1971):

> No court should substitute its evaluation of such matters for that of the Hospital Board. It is the Board, not the court, which is charged with the responsibility of providing a competent staff of doctors. The Board has chosen to rely on the advice of its Medical Staff, and the court cannot surrogate for the Staff in executing this responsibility. Human lives are at stake, and the governing board must be

> given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff. The evaluation of professional proficiency of doctors is best left to the specialized expertise of their peers, subject only to limited judicial surveillance. The court is charged with the narrow responsibility of assuring that the qualifications imposed by the Board are reasonably related to the operation of the hospital and fairly administered. In short, so long as staff selections are administered with fairness, geared by a rationale compatible with hospital responsibility, and unencumbered with irrelevant considerations, a court should not interfere. Courts must not attempt to take on the escutcheon of Caduceus.

Sosa has been repeatedly cited as precedent on this point. See Klinge v. Lutheran Charities Ass'n., 523 F.2d 56, 62 (8th Cir. 1975); Battle v. Jefferson Davis Memorial Hospital, 451 F. Supp. 1015, 1025 (S.D. Miss. 1976), aff'd, 575 F.2d 298 (5th Cir. 1978), among others. The standards for evaluating the

plaintiff's performance in this context were observed by the Committee herein. The plaintiff presented evidence both before the peer committee and before this Court which was addressed directly to the factors stated by the peer committee as the standards of care applied by it in its decision herein. He is in no position to contend that he was in any way prejudiced in the slightest by a want of understanding of the standards of care which constituted the charges against him. Any claim of a denial of substantive due process herein is without merit.

As the district court has painstakingly outlined in its opinion, the plaintiff's procedural due process rights were faithfully observed. The final peer panel which heard and made the decision in this case was composed of three members drawn from a panel selected by

the plaintiff himself.[1] He was fully advised of the charges against him and was given an adequate opportunity to provide his defense. The plaintiff has made no charge of incompetency or partiality on the part of any member of the Ad Hoc Committee. He could hardly do so in view of the fact that the members of the Committee had been in effect his selectees. Nor can he successfully complain that he was prevented in any way from presenting his answer to the charges. No more is required.

Since the plaintiff has not appealed the dismissal of his other claims, our conclusion that the plaintiff's substantive and procedural due process claims are unwarranted disposes of the appeal. The judgment of the district court dismissing the action

is accordingly

AFFIRMED.

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1 Branch v. Hempstead County Memorial Hospital, 539 F. Supp. 908, 911 (W.D. Ark. 1982).

JUDGMENT

UNITED STATES COURT OF APPEALS

for the

Fourth Circuit

CA 86-3165

NO. 88-3903

VINCENT S. TOUSSAINT, M. D.

Plaintiff-Appellant

vs.

LAURENS COUNTY HEALTH CARE SYSTEM and Russell Emerson, Edward M. Corley, Walter A. Sigman, W. Paul Culbertson, L. W. McClain, Michael R. Meeks, James L. Walker, Reese Young, James G. Ferguson, W. M. Wiley individually and in their official capacity as members of the Board of Directors of Bailey Memorial Hospital, and; CLEM P. HAM, individually and in his official capacity as Administrator of Bailey Memorial Hospital, AND; AKHTAR HUSSAIN, M.D., individually and in his official capacity as Chief of the Medical Staff at Bailey Memorial Hospital and as a member of the Executive Committee of Bailey Memorial Hospital, AND; BRUCE MARSHALL, M.D., individually and in his official capacity as a member of the Executive Committee of Bailey Memorial Hospital and as Chief of Service for Pediatrics at Bailey Memorial Hospital, AND; STEPHEN RAMSAY, M.D., individually and in his official capacity as a member

of the Executive Committee of Bailey Memorial Hospital and as Chief of Service for Pediatrics at Bailey Memorial Hospital, AND; ARVIN RAHEJA, M.D., individually and in his official capacity as Chief of service for both Surgery and Obstetrics at Bailey Memorial Hospital,

Defendants-Appellees

APPEAL FROM the United States District Court for the District of South Carolina, at Greenville.

THIS CAUSE came on to be heard on the record from the United States District Court for the District of South Carolina, at Greenville, and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now here ordered and adjudged by this Court that the judgment of the said District Court appealed from, in this cause, be, and the same is hereby, affirmed.

/s/ John M. Greacen
Clerk

IN THE DISTRICT COURT OF THE
UNITED STATES

FOR THE DISTRICT OF SOUTH CAROLINA

GREENVILLE DIVISION

Vincent S. Toussaint, M.D.,)
Plaintiff,)
)
- vs -)
)
Laurens County Health Care System,)
and Russell Emerson, Edward M.)
Corley, Walter A. Sigman, W. Paul)
Culbertson, L. W. McClain, Michael)
R. Meeks, James L. Walker, Reese)
Young, James G. Ferguson, W. M.)
Wiley, individually and in their)
official capacity as members of the)
Board of Directors of Bailey)
Memorial Hospital,)
and)
Clem P. Ham, individually and in his)
official capacity as Administrator)
of Bailey Memorial Hospital,)
and)
Akhtar Hussain, M.D., individually)
and in his official capacities as)
Chief of the Medical Staff at Bailey)
Memorial Hospital and as a member)
of the Executive Committee of Bailey)
Memorial Hospital,)
and)
Bruce Marshall, M.D., individually,)
and in his official capacity as a)
member of the Executive Committee of)
Bailey Memorial Hospital,)
and)
Stephen Ramsay, M.D., individually,)
and in his official capacities as a)
member of the Executive Committee of)

Bailey Memorial Hospital and as)
Chief of Service for Pediatrics at)
Bailey Memorial Hospital,)
)
Defendants.)

ORDER

[6:86-3165-3]

The Plaintiff instituted the within action claiming damages against the Defendants for violation of his rights of due process and equal protection under 41 U.S.C.A. section 1983, also for violation of the Unfair Trade Protection Act, Section 39-5-10 et seq of the S. C. Code of Laws, as amended, 1975, and for Commercial Disparagement. The case was tried before the Court without a Jury in Anderson, South Carolina on October 21st, October 22nd, and October 23, 1987.

FINDINGS OF FACT

Based upon the evidence and testimony presented at trial, I make the

following findings of fact:

1) The Plaintiff is a resident of Laurens County, South Carolina. He is a medical doctor specializing in General Surgery, with privileges at the Bailey Memorial Hospital, one of two hospital facilities under the direction of the Laurens County Health Care System in Laurens County, South Carolina.

2) The Laurens County Health Care System is a governmental entity and political subdivision of the State of South Carolina existing under the laws of the State of South Carolina and the County of Laurens. The Laurens County Health Care System was established in 1982 by the merger of the Clinton Hospital District wherein the Bailey Memorial Hospital is located and the Laurens Hospital District wherein the Laurens District Hospital was located. Prior to 1982 the aforesaid Districts

were separate and distinct political entities functioning under their own Boards of Directors. The Laurens County Health Care System now operates both the Bailey Memorial Hospital where the Plaintiff has Staff Privileges and the Laurens District Hospital.

3. The Defendants, Russell Emerson, Edward M. Corley, Walter A. Sigman, W. Paul Culbertson, Michael R. Meeks, James L. Walker, Reese Young, James G. Ferguson, and W. M. Wiley are now, or were formerly, members of the Board of Directors of the Laurens County Health Care System. These members of the Board of Directors are appointed by the Governor of the State of South Carolina.

4) Mr. James G. Ferguson's term expired as a member of the Board of Directors in September, 1986 and he is no longer on the Board of Directors.

Mr. L. W. McClain also is no longer a member of the Board of Directors.

5) The Defendant, Clem P. Ham, is the Administrator of the Laurens County Health Care System. He has been the Administrator of the System since its formation in 1982. Mr. Ham first became involved with the hospitals in Laurens County in 1979 when he was appointed Administrator of the Bailey Memorial Hospital.

6) The Defendants, Akhtar Hussain, Bruce Marshall, and Stephen Ramsay, are now or were formerly members of the Executive Committee of the Medical Staff of Bailey Memorial Hospital. Drs. Marshall and Hussain began practicing in Clinton, South Carolina in late 1979. Dr. Ramsay began practicing medicine at Bailey Memorial Hospital in or about 1985. Dr. Ramsay and Dr. Hussain became members of the Executive Committee of the

Medical Staff at Bailey Memorial Hospital in September, 1986.

7) Also named as a Defendant originally in this action was Arvin Raheja, M.D., but Dr. Raheja was dismissed as a party Defendant pursuant to Order of the Court.

8) The within action was instituted in December, 1986 when the Plaintiff's staff privileges in the Bailey Memorial Hospital were suspended as a result of alleged unjustified surgery, for performing three mastectomies on adolescent males for gynecomastia and for violating reasonable medical standards by discharging a patient, Mrs. Hunter, from the Hospital without ever having seen the patient prior to discharge. The suspension involving Mrs. Hunter had not at the time of the filing of the Complaint gone into

effect. Dr. Toussaint contended that he had been denied due process of law and that the Defendants had violated Section 1983. He further contended that the Defendants had conspired against him since at least 1982 to deprive him of due process of law in an attempt to remove him from the Staff of Bailey Memorial Hospital. Dr. Toussaint further set forth several pendant State claims. The complaint thereafter was amended several times, and ultimately, the causes of action in issue at trial were the alleged violations of Section 1983, the alleged violations of the Unfair Trade Protection Act for the State of South Carolina and the claim for Commercial Disparagement.

9) As a result of the allegation by Dr. Toussaint that the suspension imposed in November, 1986 was violative of his due process rights, the Court issued a temporary injunction in

December 1986. Thereafter, a hearing was held before the Court on December 17, 1986 and an Order was rendered dissolving the temporary injunction. The Defendants agreed to reinstate the peer review proceedings and it was provided by the Court in the Order of December 29, 1986 that Dr. Toussaint would be entitled to participate in the selection of an independent and impartial hearing panel to assure that he would be provided with due process. Dr. Toussaint was given three options to choose from in the selection of the panel.

10) After the filing of the initial complaint, the Plaintiff also amended his complaint to set forth several causes of action for alleged anti-trust violations. A Motion for Summary Judgment was granted by this Court dismissing all Anti-Trust claims of

the Plaintiff.

11) I find that Dr. Toussaint began practicing in the Bailey Memorial Hospital in Clinton, South Carolina which was then under the Clinton Hospital District in 1976. Since that time, the record documents a turbulent course not only with the subject Hospital System but also with the State Board of Medical Examiners, the State P.S.R.O. (the Physician Review Organization) and several other Hospitals where Dr. Toussaint applied for privileges. Dr. Toussaint ostensibly tries to link these Defendants to his problems with these other organizations which have reviewed his records and/or denied him Staff Privileges. However, there is no evidence to support this allegation. The P.S.R.O., the State Board of Medical Examiners and these other Hospitals are independent bodies not under the control

or influence of any of these Defendants.

12) I find that in 1977 Dr. Toussaint's application for staff privileges was denied at the Laurens District Hospital.

13) I further find that prior to 1979, Dr. Toussaint's temporary Staff Privileges at Doctors Memorial Hospital had been terminated and he withdrew application for permanent staff privileges at Mary Black Hospital, Spartanburg, South Carolina and Doctors Memorial Hospital in Spartanburg, South Carolina.

14) According to testimony submitted by the witnesses for the Plaintiff, Dr. Toussaint was found to be deficient in several audits conducted by the P.S.R.O commencing in 1976 and thereafter. While the Plaintiff attempted to allege some conspiracy regarding these audits to the effect that

he was singled out, his own witnesses contradicted his contention. Dr. Stanley Baker, called as a Plaintiff's witness, testified that the audits performed for vagotomys and spleenectomies were either regionwide or statewide audits wherein all doctors performing that type of surgery were audited. Even though these audits covered doctors in many counties and/or all doctors in the State performing this particular type of procedure, Dr. Toussaint was found to be deficient in comparison to other physicians. Evidence submitted by the Plaintiff substantiated that in one audit on a regionwide basis seventeen of twenty-five surgical procedures performed by Dr. Toussaint were found to be unjustified. Dr. Cantey, who was in charge of the State P.S.R.O. was also called as a witness by the Plaintiff. Dr. Cantey testified that no physician

was singled out in any audit. He further testified that the Plaintiff's surgical judgment was inferior.

15) I find that in March, 1978, Mr. Carlisle Neely, Acting Administrator of the Bailey Memorial Hospital, filed a request for corrective action against Dr. Toussaint due to disruptive behavior in the Hospital. Dr. Toussaint received a written reprimand for his disruptive behavior.

16) I find that in January, 1981, Dr. Toussaint and another physician were summarily suspended due to poor medical management of a patient. Dr. Toussaint was not singled out in the summary suspension, this suspension lasted only a few days, and was lifted after a hearing, within a reasonable period of time.

17) I find that in June, 1982,

Dr. Toussaint again received a written reprimand due to disruptive behavior within the Hospital. He was further ordered to apologize to the Nursing Staff for his abusive behavior. There was no suspension or restriction of any privileges at that time.

18) I find that in June, 1983, Dr. Toussaint was summarily suspended due to disruptive behavior including a flagrant disregard for the policies and surgical By-Laws of the Hospital. This suspension was later lifted and a release was obtained from Dr. Toussaint under date of July 13, 1983. Dr. Toussaint, as the Release documents specify, agreed that the suspension would continue in effect until July 17, 1983. I find that the Release which has been submitted into evidence releases the Health Care System and all Defendants from any possible claim Dr. Toussaint could raise as a

result of the 1983 suspension.

19) I find that in October, 1983 the S. C. Board of Medical Examiners filed a complaint against Dr. Toussaint for professional misconduct. This complaint alleged many instances of violation of the standard of care and the falsification of an application for staff privileges at one of the Hospitals at which Dr. Toussaint applied in Spartanburg. Dr. Toussaint testified that this action was dropped. It is a matter of public record, however, that prior to the evidentiary hearing, Dr. Toussaint brought an action against the Board of Medical Examiners attacking the constitutionality of the Board as a result of which the Board was declared to be unconstitutionally composed. See Toussaint vs. State Board of Medical Examiners, 285 S.C. 266, 329 S.E. 2d 433, (1985).

20) The evidence reveals that no further corrective action was taken against Dr. Toussaint until April, 1986. In April, 1986 a formal complaint was filed by Dr. Stephen Ramsay alleging illegal and unethical conduct on the part of Dr. Toussaint in interfering with a patient of Dr. Ramsay's. As a result of the formal complaint and the allegations therein, a summary suspension was instituted against Dr. Toussaint on April 22, 1986. A hearing was held on April 25, 1986 and the suspension was thereafter lifted on the same date. Therefore, Dr. Toussaint was given a hearing within a reasonable time after a proper summary suspension was imposed. Apparently, in this case, Dr. Toussaint was contacted by the mother of a child under Dr. Ramsay's care, known hereinafter as Grant, and asked to look into the situation with the child. Dr.

Ramsay was out of town and did not know that permission had been granted by the Physician who was taking his calls, for Dr. Toussaint to see the child. Further, this case was complicated due to the fact that the mother of the child was under investigation by DSS pertaining to the neglect of the child and a hearing was scheduled for the following week in Family Court pertaining to the care and/or neglect of this child. Dr. Ramsay had been involved with DSS in assisting them in the investigation.

21) In September, 1986 a Complaint was filed pertaining to Dr. Toussaint's inappropriate treatment of a newborn child which was known as the Littleton child. According to the complaints of the Nurses, Dr. Toussaint gave inappropriate instructions, incomplete orders, and failed to give

proper care to the child. After an investigation, the Executive Committee notified Dr. Toussaint that a restriction was to be imposed on his treatment of newborns in the Hospital and he was going to be required to consult with a Pediatrician in the treatment of any newborns. Dr. Toussaint filed an appeal of this recommended restriction and a hearing panel was appointed. Although a hearing was scheduled on one or more occasions, continuances were granted and prior to the institution of this action, no hearing had ever been held. The testimony establishes, however, that the restriction was never implemented and Dr. Toussaint's privileges were not reduced.

22) On or about the 17th day of November, 1986, Dr. Toussaint was suspended as a result of three mastectomies for gynecomastia performed on three young males. One of these boys

was thirteen years old and one was fourteen years old. Corrective action was instituted after a complaint was filed by the Director of Nursing on October 3, 1986 questioning the justification for this surgery. The Administrator referred this complaint to the Executive Committee of the Medical Staff for investigation. The Executive Committee forwarded the Complaint to the Surgery Committee and an Ad Hoc Committee was appointed to investigate the charges against Dr. Toussaint concerning the justification for these mastectomies. A hearing was held after due and proper notice was given to Dr. Toussaint and he attended the hearing and presented his position in regard to the justification for these procedures. The Hospital charts of these patients were so deficient that all three of the charts

failed to even document examination of the breasts which was the body part being operated upon. The Ad Hoc Committee by letter of November 12, 1986, found that the surgery was not justified, set forth numerous deficiencies existing with the cases and recommended that Dr. Toussaint be suspended for a period of thirty days.

23) After receipt of the report from the Ad Hoc Committee, the Executive Committee reviewed the findings and recommendations. The Executive Committee also concluded that there was no justification for these procedures and recommended that Dr. Toussaint receive a thirty day suspension of all Hospital privileges. The Executive Committee then directed the Hospital Administrator to notify Dr. Toussaint that his privileges would be suspended on November 17, 1986. Dr. Toussaint thereafter filed an appeal of this recommendation and the Executive

Committee notified him on November 19, 1986 that his appeal in this case, should he so desire, would be to the governing body of the Bailey Memorial Hospital and the same was to be requested in writing to the Board through the Hospital Administrator. Dr. Toussaint contends that the Executive Committee of the Medical Staff failed to follow the exact by-Law procedure and that this was a denial of his rights of due process. However, Dr. Toussaint was afforded due process in that he was granted a hearing after notice which he attended and participated in prior to any suspension being imposed. He was further notified of his appeal rights through the Board of Directors of the Health Care system which he admittedly never exercised. There is no evidence that the Executive Committee of the Medical Staff attempted to violate

or disregard Dr. Toussaint's due process rights since he did, in fact, have a hearing and present his defenses before any recommendation was made for suspension of his privileges. He was notified of rights of appeal, and did not exercise such rights of appeal.

24) During the period of time when the investigation was on-going pertaining to the mastectomy cases, the Administrator of the Health Care System received a telephone call from the Coroner of Laurens County concerning a patient known as Mrs. Hunter, who was seen in the Emergency Room on Friday night, November 7, 1986. As a result of this inquiry, the Administrator submitted a request for corrective action to the Executive Committee asking that the situation be investigated. It was determined that this patient was admitted to Bailey Memorial Hospital to Dr.

Toussaint's care and discharged by Dr. Toussaint without ever having been examined by him. He was called on numerous occasions pertaining to the patient but would not come to the Hospital even though she was very belligerent and had suffered a head injury. He instructed the Nurses to discharge the patient after she could not be controlled in the Hospital. Mrs. Hunter died within twelve hours after discharge from the Hospital. On November 12, 1986, the Executive Committee of the Medical Staff notified Dr. Toussaint to complete the medical record on the Hunter case so that they could further evaluate the situation. On November 13th, the Executive Committee considered the matter and was of the opinion that poor medical care was rendered to the patient and a summary suspension was enacted. This

summary suspension was to become effective on December 14, 1986. Dr. Toussaint requested an appeal of this potential suspension and Dr. Toussaint was notified on November 19, 1986 that an Ad Hoc Committee had been assigned to hear the case and that he would be notified of the hearing date. Prior to the effective date of the suspension, Dr. Toussaint filed the within action and this suspension was never implemented.

25) After the institution of the within action and the order of the Court of December 29, 1986, the Peer Review process was reinstituted within the Health Care System. The mastectomy cases and the Hunter case were treated as separate cases and Dr. Toussaint was afforded a hearing before an Investigatory Committee with Counsel present in each of these cases. Thereafter, an adverse recommendation was made

by the two Investigatory Committees and accepted by the Executive Committee. Accordingly, Dr. Toussaint was then granted hearings by the Executive Committee on each of the cases with Counsel present. Again, adverse recommendations were issued against Dr. Toussaint and he appealed these recommendations. Accordingly, as established by the Order of this Court on December 29, 1986, Dr. Toussaint was then allowed to hand pick the method of selection of a Special Ad Hoc Committee to hear his appeal. Although Dr. Toussaint was given three different options, he chose the option whereby he would choose six members of the Medical Staff of Bailey Memorial Hospital and from this six the Executive Committee of the Medical Staff would choose three of the six to serve as the Special Ad Hoc

Hearing Committee. The Committee ultimately consisted of two Physicians with only courtesy staff privileges, both of whom reside in Greenwood County, and one Physician who moonlights in the Emergency Room and is a fulltime employee of the State of South Carolina. Dr. Toussaint was given an adversarial hearing before this panel of his "handpicked peers" on July 7th and 13th, 1987. At this hearing, Dr. Toussaint was represented by Counsel and was allowed to present witnesses in his behalf, including expert witnesses and examine and cross-examine witnesses. After this hearing, the Special Ad Hoc Committee found that Dr. Toussaint knowingly discharged Mrs. Hunter from the Hospital without having seen or evaluated her in any way and that this was a violation of a very basic standard of medical care and could be construed as negligence had

there been any allegations of harm to the patient as a result of her manner of discharge. The Committee further found that Dr. Toussaint was grossly deficient in regards to the justification for the mastectomy cases. The Special Ad Hoc Committee by their decision recommended a sixty day period of suspension of Dr. Toussaint, with credit being given for the time previously served on suspension, a review of Dr. Toussaint's medical records and the imposition of a probationary period on his staff privileges.

26) This decision was affirmed by the Executive Committee and Dr. Toussaint appealed to the Board of Directors of the Health Care system. The Health Care System heard Dr. Toussaint's appeal and rendered its decision on October 19, 1987 approving and adopting

the decision of the Ad Hoc Committee.

27) I find that Dr. Toussaint was clearly and without question provided due process in these Peer Review proceedings pertaining to the mastectomy cases and the Hunter case, Dr. Toussaint was afforded the unusual privilege of being allowed to handpick his own peer review committee and yet now he has complained to this Court that this Committee was not fairly comprised. If Dr. Toussaint had questioned composition of this Committee, he could have chosen one of the two other options given to him in the Court's order of December 29, 1986. Dr. Toussaint never filed an objection to this Court pertaining to the options given and never asked the Court to propose any further options for selection of the Special Ad Hoc Hearing Committee. Dr. Toussaint's allegations of a prejudiced and/or unfair composition

of the Special Ad Hoc Hearing Committee are totally without merit. Dr. Toussaint further questions the action of the Board of Directors of the Health Care System in the adoption of the Ad Hoc Committee's decision. Dr. Toussaint alleges bias and prejudice on the part of several of the Board Members; however, the evidence reveals that these Board Members to whom he objected did not vote in the adoption of the decision. Furthermore, Dr. Toussaint has not presented evidence to this Court that these Board Members were biased on the issue under consideration. I find that Dr. Toussaint was treated more than fairly by the Health Care System in the Peer Review proceedings involving the mastectomy and Hunter cases and he was afforded full and complete rights of due process. Dr. Toussaint's claim to the contrary are without merit:

28) I find further, as did the Board of Directors of the Laurens County Health Care System, that during the Peer Review process, Dr. Toussaint knowingly and admittedly submitted altered medical records pertaining to the mastectomy cases in one of the hearings. Dr. Toussaint admitted upon cross-examination that he had added additional information to his office notes after he received a letter of November 12, 1986 from one of the investigating committees pointing out where his records were deficient. These records were then later submitted to an investigation committee in February, 1987 as the original records with full knowledge that they had been expanded and embellished.

29) In addition to the instances where Dr. Toussaint's staff privileges have been suspended and/or he has received official reprimands, Dr.

Toussaint claims that other acts of the Defendants indicate an on-going conspiracy to remove him from the staff and to deprive him of his rights of due process. He alleges that from at least as early as 1982 and thereafter, the Defendants, Marshall, Ramsay, and Hussain and others did collaborate, conspire and agree to instigate the formation of complaints against him which resulted in audits of medical procedures. Dr. Ramsay was not even on staff at Bailey Memorial Hospital until 1985. There is no evidence of any altercation or difficulties between Dr. Hussain and Dr. Toussaint until after Dr. Hussain became a member of the Executive Committee in September, 1986 and questioned Dr. Toussaint's medical judgment. Drs. Marshall, Ramsay and Hussain were members of the Executive Committee at the time

when many complaints were filed against Dr. Toussaint. However, the evidence reveals that none of these complaints originated with these three Defendants while they were on the Executive Committee, but were either from the Nursing Staff, the Administrator, or others pertaining to his disruptive behavior, failure to obey the rules and/or failure to act in accordance with the reasonable standard of medical care. These Defendants as members of the Executive Committee of the Medical Staff are charged under the by-laws of Bailey Memorial Hospital with the responsibility of review of their peers. They have the responsibility when complaints are made to institute investigations into these complaints if they determine the same to be well-founded. The evidence reveals that a number of complaints were not investigated against Dr. Toussaint

because the Executive Committee of the Medical Staff determined that they had no merit. Numerous other complaints were investigated and, on many occasions, Dr. Toussaint was found to have been deficient in his care of a patient or to have violated the rules. It is not conspiratorial or improper for those charged with the responsibility of peer review to investigate a physician where there is questionable conduct by such physician.

30) The Plaintiff alleges that since March of 1986, the Defendants Ramsay and Marshall have contacted his patients in an attempt to solicit complaints against him or damage his reputation. Dr. Ramsay and Marshall did on a few occasions contact patients or former patients of Dr. Toussaint in the process of investigating complaints which

had been made against Dr. Toussaint by these patients or by the Nursing Staff. I find under such circumstances that these contact with the patients were not unwarranted.

31) Dr. Toussaint alleges that the Defendants and others within the Hospital have more closely scrutinized his charts and activities and have enlisted the aid of Nurses including Fran Arscott, the Director of Nursing, to seek ways to suspend and revoke his staff privileges. The evidence does not support the allegations that the Defendants have in an unjustified manner, more closely scrutinized the charts and activities of the Plaintiff. The evidence reveals that Dr. Toussaint's problems arising from the scrutiny of his records are due to his own failure to comply with the rules and regulations of the Health Care System and his failure to

justify surgical procedures prior to performing the same. Admitted into evidence were quality assurance reports documenting Dr. Toussaint's failure on numerous occasions to comply with charting requirements, complete orders, obtaining proper consent forms, etc. The Hospital officials are required by law to audit medical records, to scrutinize questionable charts and thereby to protect the interest of the Health Care System from liability. In this age of may medical malpractice actions, the Health Care System would be negligent if it failed to investigate deficient and questionable practices. Furthermore, the quality assurance reports submitted into evidence document that Dr. Toussaint was treated with the same criteria as the other surgeons in Bailey Memorial Hospital.

32) Many of the allegations in Dr. Toussaint's Complaint and in the testimony centered around complaints arising from the Nursing Staff. Dr. Toussaint in his Complaint attributed much of this to the current Director of Nursing, Mrs. Arscott, and indicated conspiratorial conduct on her part. However, the evidence does not support his allegations. Mrs. Janet Hassell, Director of Nursing for Bailey Memorial Hospital in 1982 and 1983, testified that during her tenure as Director of Nursing, Dr. Toussaint was a continual source of disruption. The nurses under her direction at that time filed many complaints about Dr. Toussaint and she, herself, filed one or more complaints about Dr. Toussaint's disruptive behavior and failure to comply with the appropriate rules and regulations. Her testimony documented and supported the

same type of complaints filed by the nursing staff about which Dr. Toussaint now complains. She testified that Dr. Toussaint threatened the Nurses, failed to obtain proper consent forms, took unauthorized pictures of patients in the Operating Room and failed to comply with surgical by-laws.

33) Dr. Toussaint has made allegations pertaining to his being treated unfairly or complaints being filed against him due to missing charts. Mrs. Linda Brewer, Medical Records Director, testified that there was continued difficulty with Dr. Toussaint pertaining to the hospital charts. Dr. Toussaint was known to take the charts out of the hospital in violation of rules and regulations. Further, Dr. Toussaint admitted on one occasion to having left thirty charts out overnight in a surgical

suite which he characterized as inappropriate.

34) I find that the situations wherein Dr. Toussaint complains of receiving letters of reprimand, notices of investigations, and letters pertaining to deficient charts, missing charts, and such matters in his Complaint do not constitute situations wherein due process rights arise nor do they indicate conspiratorial conduct. Rather, these situations document legitimate concerns by the Health Care officials due to deficient conduct and violation of the rules by Dr. Toussaint.

35) I find that at all times the Defendants acted in their official capacities in dealing with Dr. Toussaint, either as members of the Executive Committee of the Medical Staff of the Health Care System or as Members of the Board of Directors of the Health Care

system.

36) I find that the Board of Directors prior to its decision on October 19, 1987, never acted to impose a suspension on Dr. Toussaint. The only action taken by the Board of Directors up until that time, was to lift a suspension in 1983. The Members of the Board of Directors have had no personal involvement on an individual basis other than the notification by Mr. Emerson, the Chairman of the Board of the summary suspension in April, 1986. The Board of Directors has further had very limited involvement on an official basis in dealing with suspension of Dr. Toussaint until the institution of the lawsuit. In fact, in 1986, the Minutes of the Board of Directors reflect very few occasions where the discussion of any suspension or corrective action was taken against Dr.

Toussaint. The Minutes of the Board document that on those occasions when any report was made or information given that the Board directed the Medical Staff to proceed in accordance with the By-Laws.

37) Dr. Toussaint alleges due to the violations of his rights of due process and the conspiratorial conduct on the part of the Defendants that he has suffered severe economic injury. The evidence, however, does not support these allegations. Dr. Toussaint testified that as a result of the restrictions on his privileges with newborns, which actually never went into effect, that he suffered severe damages in his pediatrics' practice. Yet upon cross-examination when confronted with the fact that prior to the time the restriction was to go into effect, he only had two newborns in the hospital for the fourteen months preceding the effective date of

such restriction, he indicated he was not aware of how many newborns he had treated.

Furthermore, Mrs. Toussaint, Dr. Toussaint's office manager, testified that for the fiscal year ending June, 1986, Dr. Toussaint's practice had the largest gross income since he had been practicing medicine. Mrs. Toussaint further admitted that the income of the practice fluctuated and this was further documented by the income tax returns received in evidence.

Even if Dr. Toussaint could establish some economic injury, the evidence does not substantiate that the cause of such injury was due to any action of the Defendants. Except for a brief period of time n 1986, Dr. Toussaint has had staff privileges in Bailey Memorial Hospital without

interruption since July 17, 1983. Dr. Toussaint has failed to submit anything more than speculation and conjecture upon which this Court could link any damages he suffered to actions of the Defendants.

38) I find that the actions of the Board of Directors of the Health Care system and the Executive Committee were at all times performed in food faith and their actions were motivated by legitimate concerns for the health and safety of patients in the Health Care facility and legitimate concerns due to the violation of rules and regulations of the Health Care System.

39) I find that there is no evidence of any unfair or deceptive act or practice by any of the Defendants which could serve as the basis for an Unfair Trade Practice action as alleged by the Plaintiff. I find further that the allegations of the Complaint and the

evidence relate only to the parties herein. Furthermore, the Laurens County Health Care System is regulated by the South Carolina Department of Health and Environmental Control and is required by DHEC regulations to have in force a Peer Review process. The System is charged with the responsibility pursuant to State Law to monitor, supervise and evaluate the Physicians who practice within the Health Care System.

40) As to the cause of action for Commercial Disparagement, the Plaintiff has alleged that the Defendants have slandered and destroyed his business reputation in the Laurens County, South Carolina market area in violation of the laws of South Carolina. There is no evidence, however, of any false publications by any of the Defendants. There is no evidence of any effort by the

Defendants to interfere with Dr. Toussaint's relations with his patients nor to discredit his practice. The evidence which Dr. Toussaint would have the Court consider in this regard pertaining to contacts with patients arose under legitimate circumstances wherein complaints were being investigated.

41) The defendants content that the Statue of Limitations in effect in this case is the two year statute of limitations set forth by Section 15-78-110 of the South Carolina Code of Laws. I find, however, that the appropriate Statue of Limitations in this case is the six year statue of limitations as set forth in Section 15-3-530 of the South Carolina Code of Laws, as amended.

CONCLUSIONS OF LAW

Based upon the above stated findings of fact, the evidence and

testimony presented at the hearing, the Court concludes as follows:

SCOPE OF REVIEW

A threshold question in a case of this nature is to determine what exactly is the "Scope of Review" of the Court. While a doctor has no constitutional right to practice in a public hospital, it has long been held that in a public hospital, the provisions of the Fourteenth Amendment must be met in granting or revoking a physician's staff privileges. Duffield v. Charleston Area Medical Center, Inc., 503 F. 2d 512 (4th Cir. 1974); Christliff v. Annapolis Emergency Hospital Association, Inc., 496 F. 2d 174 (4th Cir. 1974)

In the judicial consideration of the challenges to Hospital administration, the Court is limited in its scope or review. As stated in Sosa

v. Board of Managers of Val Verde Memorial Hospital, 437 F.2d 173, 177:

> "No Court should substitute its evaluation of such matters for that of the Hospital Board. It is the Board, not the Court, which is charged with the responsibility of providing a competent staff of doctors. The Board has chosen to rely on the advice of its medical staff, and the court can not surrogate for the staff in executing this responsibility. Human lives are at stake and the governing board must be given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff. The evaluation of professional proficiency of doctors is best left to the specialized expertise of their peers, subject only to limited judicial surveilance. (Emphasis added) The Court is charged with the narrow responsibility of assuring that the qualifications imposed by the Board are reasonably related to the operation of the Hospital and fairly administered. In short, so long as staff selections are administered with fairness, geared by a rationale compatible with hospital responsibility, and unencumbered with irrelevant considerations, a Court should not interfere. Courts must not attempt to take on the escutcheon of Caduceus."

It is the conclusion of this Court, based

upon the principles enunciated in Sosa that the scope of review of this Court does not extend to relitigate the issues of the quality of medical care rendered by Dr. Toussaint to his patients. Rather, as pertains to the Section 1983 action and the other claims resulting from the peer review proceedings, the scope of this Court is limited to the consideration of whether or not Dr. Toussaint was afforded equal protection and due process of law.

SECTION 1983 CAUSE OF ACTION

In order to establish liability under Section 1983, a plaintiff must show that the defendant, acting under the color of state law, violated a right, privilege or immunity secured by the federal constitution and laws. Maine v. Thiboutet, 448 U.S. 1 (1980). In the instant case, the plaintiff has alleged that the Defendants have conspired to

deprive and have deprived him of his liberty and property without due process and equal protection of the laws. He further alleges that the deprivation was caused by acts and procedures of the Health Care system and that the acts and procedures represented the official policy or custom of that political subdivision.

(a) Due Process

The plaintiff alleges that he was denied due process because:
(1) the defendants failed to use proper procedures in suspending his privileges;
(2) the individuals which considered his suspensions were biased; and
(3) the standards used in suspending him were impermissibly vague.

The court will consider these contentions separately.

(1) procedures

In determining whether an individual who has been deprived of a federal protected liberty or property interest was afforded due process, the court must review the following factors:

> "(1) the private interest at state; (2) the risk that the procedures used will lead to erroneous results and the probable value of the suggested procedural safeguard; (3) and the governmental interest affected."

Little v. Streeter. 452 U.S. 1, 6(1981); Matthews v. Eldridge, 424 U.S. 319, 335 (1976).

The court recognized that the private interests at stake in this case are certainly considerable; suspension of a physician not only deprives him of his livelihood for a period of time, but also has an adverse affect on professional reputation which is not easily reversed. Nevertheless, the governmental interest in protecting the unknowing public from

poor medical judgment and care is even stronger. While a physician facing possible suspension may suffer both economic harm and damage to reputation, a member of the public entrusts his health and his life to the skill and judgment of a surgeon whose services he seeks.

With this competing interest comparison in mind, the court will now address the remaining Eldridge factor with regard to Dr. Toussaint's claim, "(2) the risk that the procedures used will lead to erroneous results and the probable value of the suggested procedural safeguard".

In this regard, the court initially notes that among the basic requirements of due process are the following procedures: (1) notice of charges; (2) disclosure of evidence supporting charge; (3) opportunity to confront and cross-examine other party's

witness; (4) opportunity to present own witness or evidence; (5) opportunity to be represented by counsel; (6) impartial decision maker; (7) statement of reasons for decision. See Serafin v. City of Lexington, Nebraska, 547 F. Supp. 1118 (D. Neb. 1982). Although all of these rights may be required in a criminal type proceeding, see Rivera vs. Marcus, 696 F. 2d 174 (10th Cir. 1982).

A physician, such as the plaintiff, who is facing suspension of his hospital privileges is entitled to reasonable notice of the charges against him and a fair opportunity to be heard with respect to those charges by a panel of fair-minded physicians.

However, the courts have stopped short of requiring a full-blown judicial trial. Leiy v. Kona Hospital, 754 F.2d 1420 (9th Cir. 1985). Furthermore, the

federal constitution and laws do not preclude a hospital from establishing standards which bear a reasonable relationship to proper management of a hospital as long as they are compatible with hospital responsibility unencumbered with irrelevant considerations. See Kling v. Lutheran Charities Assoc. of St. Louis, 523 F.2d 56 (1975).

In addition, due process does not always require a hearing prior to the deprivation, for the exigencies of the situation and the fact that any due process concerns can be properly addressed by a post-deprivation hearing may justify conducting the hearing after the deprivation. Mathews v. Eldridge, 424 U.S. 319 (2975); See also Kersey vs. Shipley, 673 F.2d 730 (4th Cir. 1982).

As stated in Parratt v. Taylor, 451 U.S. 527 (1981):

"Our past cases mandate

> that some kind of hearing is required at some time before a State finally deprives a person of his property interest. The fundamental requirement of due process is the opportunity to be heard and it is an opportunity which must be granted at a meaningful time and in a meaningful manner. However, as many of the cases recognize, we have rejected the proposition that, 'at a meaningful time and in a meaningful manner' always requires a State to provide a hearing prior to the initial deprivation of property."

Because poor medical care and judgment poses such a great risk to the public, suspension of a physician's hospital privileges has been recognized as a situation where a post-deprivation hearing is justified. Christliff v. Annapolis Emergency Hospital Assoc., Inc., 496 F.2d 174 (4th Cir. 1974); Jackson vs. The Fulton-Dekalb Hospital Authority, 423 F. Supp. 1000 (N.D. Ga. 1976).

The court finds that the procedures outlined above sufficiently protect against erroneous results and assure due process. Therefore, with these due process parameters as a guide, we now turn to the plaintiff's alleged Section 1983 Violations. The evidence substantiates four occasions when Dr. Toussaint was suspended for short periods of time. Dr. Toussaint also alleges that his privileges pertaining to newborns was restricted on one occasion. These are the only instances during which Dr. Toussaint could have been deprived of any property or liberty interests and, therefore, are the relevant instances for evaluation of Dr. Toussaint's claim of lack of due process.

In January, 1981 Dr. Toussaint and another physician were summarily suspended from staff privileges for poor

medical management of a patient. Dr. Toussaint obviously was treated equally with the other physician since both were summarily suspended. The evidence documents that this suspension lasted only a few days and was as a result of legitimate concern for patient care. Further, the suspension was lifted immediately after a hearing within a reasonable period of time. Dr. Toussaint was not deprived of due process in this summary suspension.

In June, 1983 Dr. Toussaint was summarily suspended due to disruptive behavior including a flagrant disregard for the policies and surgical By-Laws of the Hospital. This suspension was later lifted after a hearing and a release was obtained from Toussaint under date of July 13, 1983. If Dr. Toussaint did, in fact, have any claim for violation of due process, the same was waived and

terminated by virtue of the release signed on July 13, 1983.

The next period of suspension involved a summary suspension in April, 1986. Dr. Toussaint was summarily suspended on April 22nd as a result of a formal complaint filed by a physician alleging illegal and unethical conduct including interference with a patient under the care of such physician. A hearing was held on April 25th and the summary suspension was lifted on April 25, 1986. Again, Dr. Toussaint was subjected to a proper summary suspension and a hearing was granted within a reasonable period of time in accordance with due process.

Dr. Toussaint alleged that the recommended restrictions in September, 1986 upon his care of newborn children also resulted in a violation of his due

process and equal protection. The evidence documents that a hearing panel was appointed, that the restriction never went into effect and, therefore, there was no denial of due process.

In regards to the Hunter case wherein a summary suspension was recommended on November 13, 1986, again there was a legitimate concern for inappropriate treatment of a patient in the Hospital. A recommendation was made that clinical privileges be suspended for a period of thirty days and the summary suspension was to go into effect on December 14, 1986. Dr. Toussaint appealed the summary suspension and he was notified on November 19, 1986 that a committee had been appointed to investigate the matter and that he would be notified of the time and place of a hearing. This suspension never went into effect. Dr. Toussaint filed the within

action prior to any hearing being granted and, therefore, there was no denial of due process since a committee had been appointed, he was to be granted a hearing, and the suspension never was effectuated.

Dr. Toussaint was suspended on or about the 17th day of November, 1986 as a result of three mastectomies for gynecomastia performed on three young males. The evidence documents, however, that prior to the suspension going into effect, Dr. Toussaint was afforded a hearing after due and proper notice, that he attended the hearing and presented his position in regard to the justification for these procedures. The record is not clear as to exactly what type of suspension was intended; however, the record is clear that Dr. Toussaint was not deprived of his rights without the

benefit of being able to appear and present his case before the imposition of any suspension. He was further not precluded from filing an appeal to the Board of Directors of the System and was notified of his right of appeal. Dr. Toussaint, however, chose not to file an appeal to the Board but rather instituted this lawsuit. Dr. Toussaint complaints that the Defendants did not follow the proper procedure as outlined in the By-Laws as he interprets them. However, all testimony indicates that the Executive Committee made a good faith effort to comply with the By-Laws; and any failure to comply appears more attributable to a misunderstanding of the By-Laws rather than an intentional attempt to circumvent their provisions.

Nevertheless, any failure on part of the Defendants to comply with the By-Laws is not dispositive of the

plaintiff's Section 1983 cause of action; the critical question is whether the defendant was, nevertheless, afforded due process. Conceres v. United States, 440 U.S. 741 (1979) (mere fact that an agency violates its own rules does not create due process violation); Bowen v. N. C. Dept. of Human Resources, 710 F.2d 1015 (4th Cir. 1983). (peer group review violates rules but procedure provided fair hearing); Goodrich v. Newport News School Board, 743 F.2d 225 (4th Cir. 1984) (School Board's failure to comply with procedures in teacher termination does not sustain a due process violation where minimal due process requirements of notice and hearing are met); See also Levitt v. Univ. of Texas at El Paso, 759 F.2d 1225 (5th Cir. 1985) (School violated own rules but afforded basic due process protection); Everhart v.

Jefferson Parish Hosp. Dist. No. 2, 757 F.2d 1567 (5th Cir. 1985).

After the reinstitution of the peer review in the November 17th suspension, Dr. Toussaint was clearly given adequate notice of the charges against him and an opportunity to be heard. Dr. Toussaint had the benefit of an attorney at each hearing and was allowed to present evidence and cross-examine witnesses. Any contention that Dr. Toussaint was not afforded adequate notice of the charges and an opportunity to be heard in the reinstituted peer review process is unsupported by the evidence.

Even if the court found that Dr. Toussaint was deprived of due process in any of the suspensions, it is doubtful that the short periods of summary suspensions are deserving of constitutional considerations. In the

recent case of Angell v. Leslie, Opinion No. 87-1511 (4th Cir. Oct. 27, 1987), the Court considered a claim under section 1983 and cited with approval the case of Carter v. Western Reserve Psychiatric Habilitation 767 F.2d 270 (6th Circuit 1985). In Carter, at 272, the Court stated: "In the case of appellant Carter, although we recognize that a two day suspension without pay constitutes a property deprivation in theory, Loudermill 721 F.2d at 561, not every such deprivation is significant enough to trigger the protection of the due process clause. Goss v. Lopez, 419 U.S. 565, 576 (1975); Bodie v. Connecticut. 401 U.S. 371, 379 (1971). Under the facts of the instant case, Carter's suspension was in the manner of routine discipline. We regard his deprivation as de minimus and not deserving of due process

consideration."

I conclude that in each of the instances of corrective action as above outlined that the Plaintiff was afforded a hearing within a reasonable time after a proper summary suspension or that he was given reasonable notice of the charges and a hearing before the imposition of any suspension of privileges. Further, I conclude that the short periods of summary suspension are not significant enough to trigger protections of the due process clause.

(2) bias of board members

Dr. Toussaint contends that he was denied due process because the Board of Directors allowed biased individuals to sit in judgment over him during the peer review process before the Executive Committee. He apparently contends that the members of the committee dislike him and therefore were predisposed to vote

against him. First of all, the vesting of substantial decision making authority in members of the medical staff who also happen to be peers of the plaintiff does not, standing alone, offend the mandates of due process. Klinge: see also Bowens v. N.C. Dept. of Human Resources, 710 F.2d 1015 (4th Cir. 1983). Furthermore, the mere fact that Dr. Toussaint and members of the Executive Committee or Hospital Board may have personal differences does not necessarily preclude the latter from serving in their official capacity:

> "The Constitution does not require that the decision making process be as antiseptic in this context as it is required to be, for example, in a criminal prosecution." Suckle v. Madison General Hospital, 362 F.Supp. 1196, 1210 (W.D. Wisc.).

In order to disqualify a hearing tribunal, actual bias rather than a mere

potential for bias must be shown, and actual bias is evidence by statements on the merits by those who must make factual determinations on contested factual issues where fact finding is critical. Staton vs. Mayes, 552 F.2d 908, 914 (1977). Statements as to policy issues related to a dispute and a recitation of charges, standing alone, do not constitute actual bias. As stated in Belsinger v. District of Columbia, 295 F. Supp. 159:

> To assume that any tribunal approaches a cause completely devoid of predictions or initial reactions is unrealistic. To nullify a ruling of a quasi-adjudicatory body on the basis of bias or prejudgment requires a substantial showing of a predetermined purpose to reach a determined end.

In the South Carolina case of Kizer v. Dorchester County Vocational Education Board of Trustees, 287 S.C.

545, 340 S.E. 2d 144, the Appellant alleged that one of the members of a school board deciding the issues of his case was biased and, therefore, his due process was violated. The school board member in question had made a statement that it would be better for the Appellant to go somewhere else to teach school. In Kizer the Supreme Court of South Carolina held that such statements are nothing more than comments reflecting a concern for the well-being of the school and do not demonstrate irrevocable prejudgment or reflect a mind effectively foreclosed to reason and persuasion for one side. "Unless there is evidence that preformed opinions of Board Members are fixed and unchangeable, or that in the deliberations after hearing all the evidence, the result was dictated by such a preformed opinion, the Appellant can not successfully maintain that he was

deprived of a fair and impartial hearing. Crane v. Mitchell County Unified School District No. 273, 233 Kansas 51, 652 P.2d 205. Kizer, at 552-53.

It is the conclusion of this Court that there is no evidence to support the Plaintiff's claim that the decision rendered against him was the result of bias, prejudice or preformed judgment. The record substantiates, that each time there was a hearing before the Executive Committee, it has been as a result of a legitimate complaint filed either by the Nursing Staff, Administrator, or some other Hospital personnel. Dr. Marshall, Dr. Hussain, and Dr. Ramsay did not, while members of the Executive Committee, initiate any complaints which were acted upon by the Committee.

Additionally, in the

reinstituted peer review proceedings Dr. Toussaint participated in the selection of the panel. Certainly, he can not now assert a valid challenge or claim of bias to the members of this panel. Additionally, in the reinstituted proceeding, it must be noted that he selected the panel members, and at no time did he complain to the Court after being granted the option which he chose. Thus, Dr. Toussaint has failed to present sufficient evidence indicating bias, prejudice or prejudgment on the part of the committees which evaluated him.

Dr. Toussaint also challenged the Board of Directors' ultimate decision in the reinstituted proceeding on the basis of bias and prejudice. However, the record documents that none of the Directors to whom he objected voted on the final decision.

(3) standards

Dr. Toussaint argues that the standards upon which the decisions were made to suspend his staff privileges were impermissibly vague and arbitrary and/or nonexistent. The Court disagrees, however, and finds that the standards, as applied, afforded due process. The Court finds merit in the statement of the Special Ad Hoc Hearing Committee in its recommended decision, "Much has been said about Standards of Practice. The Committee accepts a definition of a Standard of Medical Practice as being that manner of care or degree of skill which would be rendered by a reasonable physician under the same or similar circumstances. To the members of this Committee, Dr. Toussaint has been charged with violating two standards of practice that are so basic to the practice of medicine, that it is unlikely anyone

would bother to write them down, namely, every surgical procedure will be justifiable and appropriate and no patient will be discharged without being seen and examined by the attending physician."

It has been held that medical staff privileges may be constitutionally refused if such refusal is premised upon a reasonable basis, such as the professional and ethical qualifications of the physicians or the common good of the public and the Hospital. Foster v. Mobil County Hospital, 398 F.2d 227, 230 (5th Cir. 1968).

Furthermore, it has been recognized that, in the area of personal fitness for medical staff privileges, precise standards are difficult, if not impossible, to articulate: "The subjectives of selection simply can not be minutely codified. The governing

board of a hospital must, therefore, be given great latitude in prescribing the necessary qualifications for potential applicants." Sosa v. Board of Managers, Supra.

While Courts have differed as to exactly how general such standards may be, more recent cases have followed the teaching of Sosa, and have allowed broader or standards similar to those mentioned here. See Huffaker v. Bailey, 540 P.2d 1398; Moore v. Board of Trustees, 88 Nev. 207, 495 P.2d 605, cert. denied, 409 U.S. 879, 93 S.Ct.85. This approach is acceptable, perhaps preferable, in that, "...detailed description of prohibited conduct is concedely impossible, perhaps even undesirable, in view of rapidly shifting standards of medical excellence and the fact that a human life may be, and quite

often is, involved in the ultimate decision of the Board." North Broward Hospital District v. Mizell, 148 So.2d 1 (Fla. 1962). It is the conclusion of the Court that the standards applied in the suspension of the Plaintiff's privileges were not impermissibly vague and arbitrary.

(b) Plaintiff Failed to Establish an "Official Policy or Custom"

In order to establish a cause of action against a governmental entity under Section 1983, a plaintiff is required to prove the following elements: (1) An official policy or custom; (2) That causes the Plaintiff to be subjected to; (3) A denial of a constitutional right, Parratt v. Taylor, 451 U.S. 527, 101 S.Ct. 10908; Batista v. Rodriquez, 702 F.2d 393, 397; Moore v. City of Columbia, 284 S.C. 278, 326, S.E.2d 157. In Monell v. Department of Social

Services, 436 U.S. 658, 98 S.Ct. 2018, the United States Supreme Court held for the first time that a municipality is a person subject to liability under Section 1983 for violating another's federally protected rights. Although the municipality's liability can not be asserted on the theory of Respondeat Superior, a municipality is subject to liability if by reason of its own statue, ordinance, regulation, custom or useage it deprives a person of constitutionally protected rights.

Therefore, with regard to governmental defendants, the threshold question is not whether the official acts are unconstitutional on their fact; rather, the issue is whether the unconstitutional acts complained of were caused by a policy or custom of the municipality. Power v. City of Chicago,

644 F.2d 639 (7th Cir. 1981). it is clear, however, that the power to establish policy is not the exclusive province of the legislature, and the decision of other officials "whose acts or edicts may fairly be said to represent official policy" may give rise to municipal liability under Section 1983. Monell v. New York City Dept. of Social Services, 436 U.S. 658, 694 (1978). The Supreme Court further clarified the circumstances under which municipal liability will attach in Pembaur v. City of Cincinnati, 106 S.Ct. 1292 (1986):

> We hold that municipal liability under Section 1983 attaches where-and only where-a deliberate choice to follow a course of action is made from among various alternatives by the official or officials responsible for establishing final policy with respect to the subject matter in question.

The Laurens County Health Care system has established for the medical

staff at Bailey Memorial Hospital by-laws to govern the activities of the physicians in the hospital. Articles V, VII, and VIII of these by-laws prescribe the procedures to be followed in peer review proceedings. These particular Articles establish procedures for investigations, corrective action, summary suspension when applicable, and a fair hearing plan including appellate rights to the Board of Directors. Procedural safeguards are established in the by-laws to assure that all physicians are afforded due process. Article VIII, Sec. 1.c., states that "All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth...to assure that the affected practitioner is accorded all rights to which he is entitled."

These by-laws as adopted by the

Board constitute the 'policy' of the System. The evidence fails to sustain the plaintiff's allegation that these by-laws which are the official policy of the System caused the Plaintiff to be subjected to a deprivation of his constitutional rights.

As stated previously, the Court finds that any failure to comply with the By-Laws in regard to the November 17th suspension is more attributable to misunderstanding rather than conscious intent to circumvent provisions of the By-Laws. Therefore, any fault on the part of the governmental entity did not rise above the level of negligence, and negligent conduct alone does not constitute "official policy or custom" such to give rise to municipal liability. Pembaur vs. City of Cincinnati, 106 S.Ct. 1292 (1986); Morrash vs. Strobel, slip op. 85-117-A (4th Cir. October 6,

1987)(unpublished).

(c) Conspiracy to Violate Due Process

The Plaintiff further alleges a conspiracy to deprive him of his constitutional rights. The Plaintiff contends that a conspiracy is evidenced by letters written to him and complaints regarding his violations of rules in the Health Care System, removal of charts from the Hospital and charting deficiencies. The evidence submitted in support of these allegations is not sufficient to warrant a finding of conspiracy. He has further alleged conspiracy by the Defendants with the State P.S.R.O. and the State Board of Medical Examiners and the denial of privileges at various Hospitals. The evidence also fails to support this allegation. Rather, the evidence substantiates questions of Dr.

Toussaint's professional misconduct and deficiencies in surgical judgment.

I conclude that the actions of the Defendants in the suspensions imposed upon Dr. Toussaint were justified, based upon reasonable standards, imposed fairly and in accordance with due process. The evidence, therefore, fails to sustain the Plaintiff's cause of action for violation of Section 1983.

PLAINTIFF'S CAUSE OF ACTION FOR COMMERCIAL DISPARAGEMENT

The Plaintiff has alleged that the Defendants have slandered and destroyed his business reputation in the Laurens County, South Carolina market area in violation of the laws of the State of South Carolina. He has apparently characterized this cause of action as one for "Commercial Disparagement", a form of interference with economic relations. This is a claim

under state law and it is questionable whether such a cause of action exists in South Carolina.

In Smith v. Holt, Rinehart and Winston, Inc., 270 S.C. 446, 242 S.E. 2d 548, the Supreme Court of South Carolina held that a cause of action for interference with prospective advantage did not exist in South Carolina. Also, in the case of Columbia Management Corporation Resort Properties, Inc. of Beaufort, 279 S.C. 370, 307 S.E. 2d, 228 (1983), the Court held that tortious interference with a business relationship was not recognized cause of action in South Carolina.

Even if this tort is recognized in South Carolina, the plaintiff has failed to prove or submit any evidence or even plead the necessary elements to establish the cause of action. Prosser,

Law of Torts, Sec. 128, Injurious Falsehood, states that injurious falsehood or disparagement may result from the publication of matter derogatory to the Plaintiff's title to his property or its quality, to his business in general or to some element of his personal affairs of a kind calculated to prevent others from dealing with him, or which would otherwise interfere with his relations with others to his disadvantage. The cause of action found upon injurious falsehood resembles that for defamation but differs from it materially in the greater burden of proof resting on the Plaintiff and the necessity for special damage in all cases. "There is no presumption as in the case of personal slander that the disparaging statement is false, and the Plaintiff must establish its falsity as a part of his cause of action.... In

addition the Plaintiff must prove in all cases that the publication has played a material and substantial part in inducing others not to deal with him and that as a result he has suffered special damage." Prosser at page 920.

I conclude that the Plaintiff has failed to present sufficient evidence to establish this cause of action even if the same is recognized in South Carolina.

UNFAIR TRADE PROTECTION ACT

The Plaintiff alleges a violation of the South Carolina Unfair Trade Protection Act as set forth in Section 39-5-10, et seq, of the South Carolina Code of Laws. It is stated in Section 39-5-20 (a) that, "Unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce are hereby declared unlawful."

It was held in the case of Noack Enterprises v. Country Corner Interiors, 290 S.C. 475, 351 S.E. 2d 247, that the Legislature intended in enacting the UTPA to control and eliminate the large scale use of unfair and deceptive trade practices within the State of South Carolina." The Court further stated:

> "In our view the obvious purpose of the language 'shall include any trade or commerce directly or indirectly affecting the people of this state', then, is to circumscribe the kind of trade or commerce in the conduct of which an unfair or deceptive act or practice can serve as a basis for UTPA action. An unfair or deceptive act or practice that affects only the parties to a trade or a commercial transaction is beyond the acts embrace and we so hold."

Section 39-5-40 of the South Carolina Code of Laws further specifically declares the UTPA inapplicable to "Actions or Transactions permitted under laws administered by any regulatory body

or officer acting under statutory authority of this State, or the United States or actions of transactions permitted by any other South Carolina Law." The Laurens County Health Care system and its Board constitutes a public body created by the Laws of the State of South Carolina. The System is charged with the responsibility pursuant to state law to monitor, supervise and evaluate the physicians who practice within the Health Care System. The System is regulated and licensed by the South Carolina Department of Health and Environmental Control. Therefore, not only is the Laurens County Health Care System a public entity, but it is also supervised by an agency of the State of South Carolina.

In Carr v. United Van Lines, Inc., 289 S.C. 194, 345 S.E. 2d 734

(1986), the Plaintiff maintained that the Defendant's contract was deceptive and in violation of the UTPA. The Court stated, "As a regulated common carrier, [the defendant] is subject to Federal Statutes, regulations of the Interstate Commerce Commission and tariffs approved by the Commission." The Court held that since the contract was authorized under regulations and tariffs administered by the Interstate Commerce Commission, the transaction involved was exempt from the South Carolina Unfair Trade Practices Act. In addition, the South Carolina Supreme Court held in State Ex Rel McCloud v. Rhoades, 275 S.C. 104, that the UTPA was inapplicable to security transactions since the transactions were regulated by the Securities and Exchange Commission and under the South Carolina Uniform Securities Act.

Therefore, since the Laurens

County Health Care System is a governmental entity and is subject to regulations by the South Carolina Department of Health and Environmental Control which licenses the Hospital System and requires supervision of physicians, the Health Care System is exempt from the application of the UTPA. Furthermore, the Plaintiff has failed to establish any unfair or deceptive act or practice on the part of the Health Care System or any of the Defendants which would subject the Defendants to liability even if the UTPA were applicable in this situation.

CONCLUSION

Based upon the above stated findings of fact and conclusions of law, it is the decision of this Court that the Plaintiff has failed to establish and prove causes of action for violation of

42 U.S.C.A., Section 1983, or for violations of the Unfair Trade Practice Act of the State of South Carolina, or for Commercial Disparagement.

IT IS, THEREFORE, ORDERED, ADJUDGED AND DECREED that judgment be, and the same is, hereby granted in favor of the Defendants and the Plaintiff's claims for relief are denied.

IT IS SO ORDERED.

/s/G. Ross Anderson, Jr.
G. Ross Anderson, Jr.,
United States District Judge

Dated: November 24, 1987

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

VINCENT S. TOUSSAINT, M. D.)
)
vs.)
)
LAURENS COUNTY HEALTH CARE)
SYSTEM; RUSSELL EMERSON;)
EDWARD M. CORLEY; WALTER A.)
SIGMAN; W. PAUL CULBERTSON;)
L. W. MCCLAIN; MICHAEL R. MEEKS;)
JAMES L. WALKER; REESE YOUNG;)
JAMES G. FERGUSON and W. M.)
WILEY, individually and in)
their official capacity as)
members of the Board of)
Directors of Bailey Memorial)
Hospital; CLEM P. HAM,)
individually and in his)
official capacity as)
Administrator of Bailey)
Memorial Hospital; AKHTAR)
HUSSAIN, M. D., individually)
and in his official capacities)
as Chief of the Medical Staff)
of Bailey Memorial Hospital and)
as a member of the Executive)
Committee of Bailey Memorial)
Hospital; BRUCE MARSHALL, M. D.)
individually and in his)
official capacity as a member)
of the Executive Committee of)
Bailey Memorial Hospital;)
STEPHEN RAMSEY, M. D.)
individually and in his)
official capacity as a member)
of the Executive Committee of)
Bailey Memorial Hospital and as)
Chief of Service for Pediatrics)
at Bailey Memorial Hospital)

JUDGMENT IN A CIVIL ACTION

C/A No. 86-3165-3

Pursuant to the Order of this Court dated October 21, 1987, summary judgment is hereby entered for the defendants on their Anti-Trust cause of action. The remaining actions came before the Court for trial, the issues having been tried and a decision having been rendered, it is therefore,

ORDERED AND ADJUDGED that the plaintiff take nothing, that the action be dismissed on the merits, and that the above name defendants recover of the plaintiff, Vincent S. Toussaint, M. D., their costs of action.

Dated at Greenville, S. C. this 27th day of November 1987.

ANN A BIRCH, CLERK

By: /s/ Carolyn Moss
Deputy Clerk

FORM APPROVED:

/s/ G. Ross Anderson, Jr.
G. Ross Anderson, Jr.
United States District Judge